96TH CONGRESS 2d Session } HOUSE OF REPRESENTATIVES { REPORT No. 96-978

HEALTH PROFESSIONS EDUCATIONAL ASSISTANCE AND NURSE TRAINING AMENDMENTS OF 1980

REPORT

BY THE

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE

together with

ADDITIONAL AND MINORITY VIEWS

[To accompany H.R. 7203]

[Including cost estimate of the Congressional Budget Office]

MAY 15, 1980.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

---

U.S. GOVERNMENT PRINTING OFFICE

62-655 O WASHINGTON : 1980

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE

HARLEY O. STAGGERS, West Virginia, *Chairman*

JOHN D. DINGELL, Michigan
LIONEL VAN DEERLIN, California
JOHN M. MURPHY, New York
DAVID E. SATTERFIELD III, Virginia
BOB ECKHARDT, Texas
RICHARDSON PREYER, North Carolina
JAMES H. SCHEUER, New York
RICHARD L. OTTINGER, New York
HENRY A. WAXMAN, California
TIMOTHY E. WIRTH, Colorado
PHILIP R. SHARP, Indiana
JAMES J. FLORIO, New Jersey
ANTHONY TOBY MOFFETT, Connecticut
JIM SANTINI, Nevada
ANDREW MAGUIRE, New Jersey
EDWARD J. MARKEY, Massachusetts
THOMAS A. LUKEN, Ohio
DOUG WALGREN, Pennsylvania
ALBERT GORE, Jr., Tennessee
BARBARA A. MIKULSKI, Maryland
RONALD M. MOTTL, Ohio
PHIL GRAMM, Texas
AL SWIFT, Washington
MICKEY LELAND, Texas
RICHARD C. SHELBY, Alabama
ROBERT T. MATSUI, California

JAMES T. BROYHILL, North Carolina
SAMUEL L. DEVINE, Ohio
TIM LEE CARTER, Kentucky
CLARENCE J. BROWN, Ohio
JAMES M. COLLINS, Texas
NORMAN F. LENT, New York
EDWARD R. MADIGAN, Illinois
CARLOS J. MOORHEAD, California
MATTHEW J. RINALDO, New Jersey
DAVE STOCKMAN, Michigan
MARC L. MARKS, Pennsylvania
TOM CORCORAN, Illinois
GARY A. LEE, New York
TOM LOEFFLER, Texas
WILLIAM E. DANNEMEYER, California

KENNETH J. PAINTER, *Acting Chief and Staff Director*
ELEANOR A. DINKINS, *First Assistant Clerk*
GEORGE E. HARDY, JR., *Professional Staff*
LEWIS E. BERRY, *Minority Counsel*

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

HENRY A. WAXMAN, California, *Chairman*

DAVID E. SATTERFIELD III, Virginia
RICHARDSON PREYER, North Carolina
ANDREW MAGUIRE, New Jersey
THOMAS A. LUKEN, Ohio
DOUG WALGREN, Pennsylvania
BARBARA A. MIKULSKI, Maryland
PHIL GRAMM, Texas
MICKEY LELAND, Texas
RICHARD C. SHELBY, Alabama
JOHN M. MURPHY, New York
HARLEY O. STAGGERS, West Virginia
(*Ex Officio*)

TIM LEE CARTER, Kentucky
SAMUEL L. DEVINE, Ohio
DAVE STOCKMAN, Michigan
WILLIAM E. DANNEMEYER, California
GARY A. LEE, New York
JAMES T. BROYHILL, North Carolina
(*Ex Officio*)

MARGERY A. COLLOFF, *Staff Director*
WILLIAM V. CORR, *Counsel*
TIM WESTMORELAND, *Assistant Counsel*
BRIAN BILES, *Senior Staff Associate*
FRANCES LEE DE PEYSTER, *Staff Associate* (*Minority*)

96TH CONGRESS } HOUSE OF REPRESENTATIVES { REPORT
2d Session } { No. 96-978

HEALTH PROFESSIONS EDUCATIONAL ASSISTANCE AND NURSE TRAINING AMENDMENTS OF 1980

MAY 15, 1980.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. STAGGERS, from the Committee on Interstate and Foreign Commerce, submitted the following

REPORT

together with

ADDITIONAL and MINORITY VIEWS

[To accompany H.R. 7203]

[Including cost estimate of the Congressional Budget Office]

The Committee on Interstate and Foreign Commerce, to whom was referred the bill (H.R. 7203) to amend the Public Health Service Act to revise and extend the programs for the National Health Service Corps and to revise and extend the programs of assistance under titles VII and VIII of such act for the education of health professions personnel, and for other purposes, having considered the same, reports favorably thereon with amendments and recommend that the bill as amended do pass.

The amendments (stated in terms of the page and line numbers of the introduced bill) are as follows:

Page 4, line 13, strike out "and who" and all that follows through line 17 and insert in lieu thereof a comma.

Page 5, insert after line 10, the following new paragraph:

(4) Section 331 is amended by redesignating subsections (g) and (h) as subsections (h) and (i), respectively, and by adding after subsection (f) the following new subsection:

"(g)(1) The Secretary shall, by rule, prescribe conversion provisions applicable to any individual who, within a year after completion of service as a member of the Corps described in subsection (a)(1)(C), becomes a commissioned officer in the Regular or Reserve Corps of the Service.

"(2) The rules prescribed under paragraph (1) shall provide that in applying the appropriate provisions of this Act

which relate to retirement, any individual who becomes such an officer shall be entitled to have credit for any period of service as a member of the Corps described in subsection (a)(1)(C).".

Page 5, strike out lines 11 through 19 and insert in lieu thereof the following:

(b)(1)(A) Section 332(a)(1) (42 U.S.C. 254e(1)) is amended by striking out "which the Secretary determines" each place it occurs and inserting in lieu thereof "which as determined under this section".

(B) Section 332(c) is amended to read as follows:

"(c)(1) The Secretary shall refer a proposed designation of an area, population group, or facility (other than a Federal medical facility) to each health systems agency for a health service area which includes such area, group, or facility or if such an area, group, or facility is in a health service area for which a health systems agency has not been designated, to the State health planning and development agency for the State in which the area, group, or facility is located. Each health systems agency and State health planning and development agency to which a proposed designation has been referred shall be given a reasonable period to review the designation and approve or disapprove the designation. In making such a review the agency shall consider—

"(A) the criteria established under subsection (b),

"(B) the recommendation of the Governor of each State in which the area, population, or facility under consideration for designation is in whole or part located,

"(C) the comments of all interested persons and the comments of the appropriate health professions societies in such area or whose members serve such population or facility, and

"(D) the extent to which individuals who are (i) residents of the area, members of the population group, or patients in the facility, and (ii) entitled to have payments made for medical services under title XVIII or XIX of the Social Security Act, cannot obtain such services because of suspension of physicians from the programs under such titles.

The reviewing agency shall give written notice to health professions societies described in subparagraph (C) of the review of a proposed designation, and the societies shall be permitted to submit their comments on a proposed designation to the reviewing agency during the 90-day period beginning on the date the agency notifies it of the review of the proposed designation.

"(2) Upon completion of its review of a proposed designation, the reviewing agency shall approve or disapprove the designation and submit to the Secretary a detailed statement in writing of the reasons for its decision.

If an agency approves a proposed designation, the Secretary shall, within the sixty-day period beginning on the date the Secretary receives the decision of the agency, make the designation unless the Secretary, within such period, determines the decision of the agency is not supported by the criteria established under subsection (b) and the other matters considered by the agency in making its decision and submits to the agency a detailed statement of the reasons for such determination. If an agency disapproves a proposed designation, the Secretary may not make the designation unless the Secretary, within the sixty-day period beginning on the date the Secretary receives the decision of the agency, determines the decision of the agency is not supported by the criteria established under subsection (b) and the other matters considered by the agency in making its decision and submits to the agency a detailed statement of the reasons for such determination.".

(C) Section 332(d) is amended by adding at the end the following: "The revision of a designation shall be subject to the same review and approval and disapproval by health systems agencies and State health planning and development agencies as is prescribed by subsection (c) for designations.".

(D) Section 332(g) is amended by inserting "or the revision of a health manpower shortage area" immediately before the period.

(E) The amendments made by this paragraph shall take effect one year after the date of the enactment of this Act.

Page 11, insert after line 5 the following:

(4) Section 334(b) is amended by adding at the end the following:

"(4) In determining whether to grant a waiver under paragraph (1) or (2), the Secretary shall not discriminate against a public entity."

Page 11, line 6, strike out "(4)" and insert in lieu thereof "(5)".

Page 24, insert after line 15 the following:

(e) Paragraph (1) of section 737 (42 U.S.C. 294j(1)) is amended to read as follows:

"(1) The term 'eligible institution' means a school of medicine, osteopathy, dentistry, veterinary medicine, optometry, pharmacy, podiatry, or public health within the United States which is accrediated by a recognized body or bodies approved for such purpose by the Secretary of Education.".

Page 24, line 16, strike out "(e)" and insert in lieu thereof "(f)".

Page 39, beginning in line 23, strike out "training centers for the allied health professions,"; and in line 12 on page 40 strike out ", training centers.".

CONTENTS

	Page
Legislative background	4
Summary of legislation	4
Cost of legislation	7
Committee proposal:	
Title I—National Health Service Corps Programs	5
Title II—Health Professions Programs Under Title VII	6
Construction assistance	37
Student assistance	41
Institutional support	51
Project grants and contracts	62
Public health personnel	88
Environmental and occupational health personnel needs—Study	95
Allied health professions	98
Title III—Nurse training	102
Title IV—Graduate Medical Education National Advisory Committee	109
Program oversight	112
Inflation impact statement	112
Agency reports	113
Congressional Budget Office cost estimate	113
Section-by-section analysis	115
Changes in existing law made by the bill, as reported	134
Minority views to H.R. 7203	220

Legislative Background

Legislation to amend the Public Health Service Act to revise and extend the programs for the National Health Service Corps and to revise and extend the programs of assistance under titles VII and VIII of such Act for the education of health professions personnel, and for other purposes, H.R. 6802, was introduced on March 12, 1980, by Mr. Waxman, Mr. Preyer, Mr. Maguire, Mr. Leland, and Mr. Carter. Hearings were held on H.R. 6802 and all similar or identical bills on March 20, 21, 24, 26, and 27, 1980. The bill was subsequently considered in open session by the Subcommittee, amended, reported by voice vote of April 23, 1980, and reintroduced as two clean bills, H.R. 7203 (covering the provisions contained in Titles I through IV of H.R. 6802) and H.R. 7204 (covering the provisions contained in Title VI of H.R. 6802) on April 29, 1980.

H.R. 7203, a bill to amend the Public Health Service Act to revise and extend the programs for the National Health Service Corps and to revise and extend the programs of assistance under Title VII and VIII of such Act for the education of health professions personnel, and for other purposes, was introduced on April 29, 1980, by Mr. Waxman, Mr. Preyer, Mr. Maguire, Mr. Walgren, Mr. Leland, Mr. Murphy of New York, and Mr. Carter. The bill was considered in open session by the Committee on Interstate and Foreign Commerce, amended, and ordered reported by voice vote on May 7, 1980.

Summary of Legislation

Existing authorities for: (1) programs of the National Health Service Corps; (2) programs of assistance for health professions education and training in Title VII of the Public Health Service Act; and (3) programs of assistance for nurse training in Title VIII of the Public Health Service Act, expire at the end of fiscal year 1980.

This measure provides extensions, revisions, and authorizations for

these programs for fiscal years 1981, 1982, and 1983. The principal provisions of H.R. 7203, as reported by the Committee on Interstate and Foreign Commerce, include:

Title I—National Health Service Corps Programs

(1) Extension and revision of the National Health Service Corps and the National Health Service Corps Scholarship program through fiscal year 1983.

(2) Authorization for the Secretary to assign members of the National Health Service Corps to private non-profit and public organizations as employees of those organizations, rather than as Federal employees, and to make grants to those organizations to assist them in meeting the salary requirements of a National Health Service Corps member. In addition, a requirement is included that the Secretary promulgate rules prescribing conversion provisions which shall apply to those members of the Corps who are so assigned and who, within a year after completion of such service, elect to become Commissioned Officers in the Public Health Service.

(3) Expansion of the number of health manpower shortage areas in which a National Health Service Corps scholarship recipient can enter into the private practice of his or her profession to fulfill service obligations.

(4) Provision of a new system for designating health manpower shortage areas, under which Health Systems Agencies (HSAs) would review all proposed designations (including revisions of designation) and approve or disapprove same. HSAs would be required to consider criteria established in the Public Health Service Act, the comments of appropriate health professions societies, and other matters. The Secretary could review the HSA's decision and, with finding of cause, reverse it.

(5) Provison of a requirement that health professions societies have 90 days to comment on the assignment of a member of the National Health Service Corps to a health manpower shortage area.

(6) Provision of a requirement that the Secretary enter into agreements with qualified State and local governments and with public and private nonprofit entities which have expertise in planning, developing, and operating centers for the delivery of primary health care. These entities would have to be able to perform certain functions essential to the establishment and operation of a health center.

(7) Provision of a requirement that the Secretary not discriminate against public entities in determining whether to grant a waiver of National Health Services Corps assignee cost-sharing requirements.

(8) Establishment of a National Health Service Corps revolving trust fund to receive all deposits to the National Health Services Corps required under the current cost sharing provisions of the program, and to be used to carry out future program operations.

(9) Authorization for the Secretary to make grants or enter into contacts for programs to better prepare National Health Service Corps scholarship recipients to effectively provide health services in a health manpower shortage area.

(10) Provision of a requirement that the Secretary evaluate current criteria for the designation of health manpower shortage areas, and report the results of that evaluation to the Congress.

TITLE II—HEALTH PROFESSIONS PROGRAMS UNDER TITLE VII

(11) Extension of programs of institutional support (capitation) to health professions institutions with: (1) repeal of maintenance of enrollment requirements, and (2) provision of declining authorizations of appropriations over the next three fiscal years to "phase-down" this program (schools of public health and nursing are not included in the "phase-down" effort).

(12) Extension of the programs of assistance for departments of family medicine, general internal medicine, and family medicine and general practice of dentistry through fiscal year 1983.

(13) Extension of the program of support for Area Health Education Centers (AHECs) through fiscal year 1983. Provides that AHECs formerly supported for development may receive additional support for projects to improve the distribution of health professionals.

(14) Extension of the programs of assistance for physicians assistants and dental auxiliaries through fiscal year 1983.

(15) Extension of the program of educational assistance to individuals from disadvantaged backgrounds. Focuses the program on health professions schools by requiring that 80 percent of the funds appropriated be provided to such institutions.

(16) Extension of the authority for assistance to medical schools which are converting from two year to full four year degree granting institutions. Programs for start-up (health professions institutions other than schools of medicine, osteopathy and dentistry), curriculum grants, and financial distress are also extended through fiscal year 1983.

(17) Extension of programs of Federal loan guarantees for projects for remodeling, renovation, or alteration of health professions teaching facilities through fiscal year 1983.

(18) Provision of construction grant authority for health professions educational institutions with a limitation on the availability of such funds to institutions which offer the first two years of education leading to the degree of doctor of medicine and which intend to become four year medical schools.

(19) Extension of the Federal health professions student loan guarantee program (HEAL) with the following changes:

(a) increasing the annual and total loan limits to $20,000 and $80,000 for students of medicine, osteopathy, and dentistry;

(b) allowing the interest to be accrued, rather than be paid during training years;

(c) providing a graduated repayment plan; and

(d) increasing the allowable interest rate to the average of the 90 day Treasury bills auctioned in the previous quarter plus 2 percent.

(20) Extension of the health professions student loan program through fiscal year 1983.

(21) Extension of the Exceptional Financial Need (EFN) scholarship program through fiscal year 1983 with the provision that such scholarships may be made to second year, as well as first year, students.

(22) Extension and recodification of existing programs of support for public health.

(23) Authorization of public health programs for departments of preventive or community medicine or dentistry, training in preventive medicine, and faculty and curricula development in health administration.

(24) Extension of existing programs of support for allied health personnel.

Title III—Nurse Training

(25) Extension of programs for advanced nurse training, nurse anesthetist traineeships, scholarships for nursing students, and loan guarantees and interest subsidies for construction projects for schools of nursing.

(26) Extension of grant program for construction projects for schools of nursing; eligibility is limited to schools located in health manpower shortage areas.

(27) Extension of the program of institutional support for schools of nursing (capitation), limiting the support to $200 per student or full-time equivalent in 1981, $210 in 1982, and $220 in 1983. Requirements for participation in the institutional support program are enrollment maintenance and one of six additional options.

(28) Extension of the program of grants for special projects for nurse training with the elimination of eligibility of projects for mergers between hospitals and academic institutions, curriculum changes, and inservice training for aides and orderlies.

(29) Extension of the program of nursing student loans; eligibility is limited to students from low-income or disadvantaged backgrounds; interest rates are raised to 6 percent.

Title IV—Graduate Medical Education National Advisory Committee

(30) Provision of statutory authority for the existing Graduate Medical Education National Advisory Committee (GMENAC). Provides for the Committee to consist of 23 members, including five ex-officio members.

(31) Provision of requirements that the Committee study the need for and supply of physicians by medical specialty and recommend goals for the distribution of physicians by specialty.

(32) Provision of a requirement that the Committee consult with appropriate entities including the Coordinating Council on Medical Education.

Cost of Legislation

H.R. 7203 provides specific authorizations of appropriations for fiscal years 1981, 1982, and 1983 in the amounts shown in Table 1. The total authorization of appropriations in H.R. 7203 for fiscal year 1981 is $649.252 million; for fiscal year 1982 is $759.031 million; and for fiscal year 1983 is $861.316 million. The authorization for comparable programs in fiscal year 1980 was $1,036.824 million; the fiscal year 1980 appropriation totaled $544.636 million.

Table 2 presents a comparative history of authorizations and appropriations for programs authorized in H.R. 7203 by Public Health Service Act Title.

TABLE 1.—HEALTH PROFESSIONS EDUCATIONAL ASSISTANCE AND NURSE TRAINING AMENDMENTS OF 1980—FISCAL DATA

[In millions of dollars]

Public Health Service Act section	1978		1979		1980		Authorizations in H.R. 7203		
	Authorization	Appropriation	Authorization	Appropriation	Authorization	Appropriation	1981	1982	1983
TITLE I—NATIONAL HEALTH SERVICE CORPS PROGRAMS									
338(a). National Health Service Corps	47	42.565	64	62.969	82	70	94	145	205
756. National Health Service Corps Scholarships	75	60	140	75	200	85.5	92	101	109
Subtotal (title I)	122	102.565	204	137.969	282	155.5	186	246	314
TITLE II—HEALTH PROFESSIONS PROGRAMS UNDER TITLE VII									
Part A—Construction assistance:									
720. Health facilities construction	40	8.5	40	0	40	1	15		
726. Loan guarantees and interest subsidies for construction of teaching facilities	2	2	3	3	3	4.3			
Part B—Student assistance:									
727. Insured loans to graduate students in health professions schools (HEAL)	1.5		(1)		(1)		(2)		
742. Health professions student loans (HPSL)	26	20	27	10	28	16.5	20	22.5	25
758. "Exceptional need scholarships"	16	5	17	7	18	10	30	40	50
759. Lister Hill scholarships	.16	0	.24	0	.32	0			
Part C—Institutional support:									
770(e)(1). Capitation/institutional support—Medicine	124.182	84.111	131,683.8	66.5	139.400	49.679	37.259	24.836	12.418
770(e)(2). Capitation/institutional support—Osteopathy	8.680	6.021	9.338	6.400	10.160	3.872	2.904	1.936	.968
770(e)(3). Capitation/institutional support—Dentistry	43.798	29.968	45.410	23.2	46.910	16.197	12.148	8.099	4.049
770(e)(5). Capitation/institutional support—Veterinary medicine	10.220	5.1	10.549	4.48	10.705	3.6	2.7	1.8	.9
770(e)(6). Capitation/institutional support—Optometry	3.205	1.6	3.273	1.36	3.366	1.058	.794	.529	.265
770(e)(7). Capitation/institutional support—Pharmacy	16.990	10.1	17.110	7.6	17.368	6.05	4.538	3.025	1.513
770(e)(8). Capitation/institutional support—Podiatry	2.268	1.2	2.271	.96	2.285	.812	.609	.406	2.03
Part D—Project grants and contracts:									
780. Departments of family medicine	10	0	15	0	20	9.5	15	20	25
781. Area health education centers	20	17	30	20	40	21	21	28	30
783. Physician and dental assistants	25	9.1	30	9.1	35	13.1	14	15	16
784. General medicine and pediatrics—Training and traineeships	15	15	20	17.5	25	19.5	23	30	32
786. Family medicine and general practice dentistry	45	45	45	45	50	40.5	50	75	80

787. Disadvantaged individuals	20	14.5	20	18	20	18.568	30	33	36
788(e). Institutions	25		25		25		10	12.5	15
(1) Start-up/conversion		(1)2		(1)5		(1)2.7			
(2) Financial distress		(2)3		(2)5		(2)5	[3] (2)20	[3] (2)20	[3] (2)20
(3) Interdisciplinary training }		(3)(4)4		(3)(4)7.14		(3)(4)8.5			
(4) Curriculum development }									
Enviromental and occupational health personnel study							1	1	1
785. Occupational health	5	0	8	0	10	0			
782. Education of U.S. students from foreign medical schools	2	2	3	2	4	0			
789. EMS training	10	6	10	3	5	3	(4)	(4)	(4)
Part E—Public health personnel:									
770(e)(4). Capitation/institutional support—Public health redesignated as sec. 791)	9.740	5.9	10.462	5.9	11.060	6.45	7	8	9
748. Public health traineeships (redesignated as sec. 792)	7.5	7	9	7	10	7	8	9	10
792. Special projects—Public health and health administration (redesignated as sec. 793)	5.0	5.0	5.5	5.0	6.0	5.0	5.0	5.5	6.0
794. Midcareer training							1.5	2.5	3.0
791. Graduate programs in health administration (redesignated as sec. 794A)	3.250	3	3.500	3	3.750	3	4.0	4.5	5.0
749. Health administration traineeships (redesignated as sec. 794B)	2.5	1.5	2.5	2	2.5	2	2.5	3	3.5
794(C). Departments of preventive medicine							2.0	3.0	4.0
794(D). Residency training in preventive medicine							6	7	8
794(E). Special curriculum development projects for graduate programs in health administration							3	4	5
794(F). Faculty development programs							1	1	1
Part F—Allied health personnel:									
796. Allied health project grants	22.0	16.5	24.0	10.5	26.0	8.7	9.0	9.5	10.0
797. Allied health traineeships	4.5	3.0	5.0	2.5	5.5	1.3	1.3	1.4	1.5
798. Allied health assistance to disadvantaged individuals	1.0	.5	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Subtotal (title II)	527.493	333.6	573.836	298.14	651.824	288.886	361.252	397.031	417.316
TITLE III—NURSE TRAINING									
801. Construction grants	20	3.5	0	0	2	0	1	1	1
805. Loan guarantees and interest subsidies for construction of teaching facilities	1	0	0	0	1	0	0	0	0
810. Capitation	55	30	30	24	24	24	25	27.5	30
815. Financial distress grants	5	0	0	0	0	0	0	0	0
820. Special project grants and contracts	15	15	15	15	17	15	15	17.5	20
821. Advanced nurse training programs	25	12	12	12	13.5	12	12	13.5	15
822. Nurse practitioner programs	25	13	13	13	15	13	17	18.5	20
830. Traineeships for advanced training	25	13	13	13	15	13	15	17.5	20
831. Traineeships for training of nurse anesthetists	0	0	0	0	2	0	2	3	4
836. Student loan repayment		1.5		.75		.75			
837. Student loans	35	22.5	22.5	13.5	13.5	13.5	15	17.5	20

TABLE 1.—HEALTH PROFESSIONS EDUCATIONAL ASSISTANCE AND NURSE TRAINING AMENDMENTS OF 1980—FISCAL DATA—Continued

[In millions of dollars]

Public Health Service Act section	1978		1979		1980		Authorizations in H.R. 7203		
	Authorization	Appropriation	Authorization	Appropriation	Authorization	Appropriation	1981	1982	1983
845. Scholarships	0	9	0	9	0	9			
Subtotal (title III)	206	119.5	105.5	100.25	103	100.25	102	116	130
Total (titles I, II, and III)	855.493	555.665	883.336	536.359	1,036.824	544.636	649.252	759.031	861.316

[1] Such sums as necessary.
[2] No authorization required.
[3] Separate authority for financial distress is established in this bill.
[4] Reauthorized in Public Law 96–142.

TABLE 2.—COMPARATIVE HISTORY OF AUTHORIZATIONS AND APPROPRIATIONS FOR PROGRAMS AUTHORIZED IN H.R. 7203, BY PUBLIC HEALTH SERVICE ACT TITLE

[In millions of dollars]

Public Health Service Act title	1978		1979		1980		Authorizations in H.R. 7203		
	Authorization	Appropriation	Authorization	Appropriation	Authorization	Appropriation	1981	1982	1983
Title III (National Health Service Corps)	47	42.565	64	62.969	82	70	94	145	205
Title VII (Health Professions Educational Assistance)	602.493	393.6	713.836	373.14	851.824	374.386	453.252	498.031	526.316
Title VIII (Nurse Training)	206	119.5	105.5	100.25	103	100.25	102	116	130
Total	855.493	555.665	883.336	536.359	1,036.824	544.636	649.252	759.031	861.316

COMMITTEE PROPOSAL

Title I—National Health Service Corps

1. Background

a. Public Law 91–623, The Emergency Health Personnel Act of 1970

In 1970, Congress enacted Public Law 91–623, the Emergency Health Personnel Act, which amended Title III of the Public Health Service (PHS) Act to authorize a program for PHS health personnel to volunteer their services in health manpower shortage areas. The need to encourage health personnel to serve in such areas resulted from the geographic maldistribution of health professionals in the country. During hearings on the 1970 legislation, a sponsor of one bill underscored the need for legislation:

There can be no doubt but that this Nation suffers from a serious shortage of doctors, nurses, and other medical personnel, a shortage that is reflected both in absolute numbers and the growing cost of securing such personnel. And yet, as serious as this problem is on a national level, it approaches crisis proportions in many low-income and rural areas. For years, ghetto areas have been virtually unable to attract doctors and other backup health-care technicians to serve their residents because both the income potential and the living conditions there are very much inferior to those offered by other areas competing for the services of these needed medical personnel. Similarly, any number of small communities are unable to attract a sufficient number of medical professionals and paraprofessionals because there is little "future" in such towns and villages.

Hence, the end result has been that often the normal medical needs of the residents of low income and rural areas go unmet, and only in emergencies do the residents feel compelled to travel outside their communities for such assistance. Unfortunately, this medical deficiency in such communities does not appear likely to be met by existing structures. A new approach, an innovation, is needed in order to render much needed assistance in meeting the medical needs of the residents of such communities.[1]

The House Interstate and Foreign Commerce Committee report on the 1970 legislation indicated striking differences in the numbers of physicians available to provide care between rural and urban areas. In 1963, there were 181 physicians per 100,000 population in large metropolitan areas compared to 50 per 100,000 in isolated rural areas.[2] The declining supply of general practitioners contributed to the decreasing numbers of physicians serving rural areas. This occurred because general practitioners tended to be more evenly distributed throughout the population whereas specialists, whose numbers were increasing, were more likely to locate disproportionately in urban areas. The supply of general practitioners had declined from 90 per 100,000 population in 1940 to 31 per 100,000 in 1967.[3]

[1] U.S. Congress. House. Committee on Interstate and Foreign Commerce, Emergency Health Personnel Act of 1970. Hearings, 91st Congress, 2d session on H.R. 19246, H.R. 19338, H.R. 19616, H.R. 19659, and S. 4106, Nov. 24 and 25, 1970. Washington, U.S. Government Printing Office, 1970, pp. 33–34.

[2] U.S. Congress. House. Committee on Interstate and Foreign Commerce. Emergency Health Personnel Act of 1970; Report to Accompany H.R. 19860. Washington, U.S. Government Printing Office, 1970 (91st Congress, 2d session, H. Rept. No. 91–1662), p. 2.

[3] Ibid.

Public Law 91–623 represented the first substantial congressional effort to legislate solutions to the problem of geographic maldistribution of health professionals. Debate on the legislation indicated strong congressional support for the program concept of encouraging health professionals to practice in areas with inadequate health services and supplies of health personnel. The administration unsuccessfully requested postponement of consideration of the legislation until after completion of several Department of Health, Education, and Welfare (DHEW) activities, including a "Health Options" effort to develop a new health strategy. The Administration noted that addition of a new authority to the PHS at a time when all authorities were being evaluated would not be productive.[4]

As enacted, Public Law 91–623 authorized an identifiable administrative unit within PHS to be staffed by commissioned officers and other PHS personnel to provide health care and services to persons residing in "critical health manpower shortage" areas. The Act specified that in order to be assigned PHS personnel, a geographic area must meet certain conditions. For example, the area had to be designated by DHEW as having a critical health manpower shortage. Assignments of personnel would be made only upon the request of a State or local health agency, or other public or private nonprofit health organizations. State and district medical societies (or other professional societies as appropriate) and the local government were also required to certify that such personnel were needed.

b. Public Law 92–585, The Emergency Health Personnel Act Amendments of 1972

The Emergency Health Personnel Act Amendments of 1972, Public Law 92–585, officially established the National Health Service Corps (NHSC) as a specified unit within PHS to implement the 1970 Emergency Health Personnel Act. The 1972 Act also amended Title VII of the PHS Act to authorize a NHSC scholarship program for health professionals to provide an adequate number of trained physicians, dentists, nurses, and other health specialists for the Corps.

Implementation of the original program established by the 1970 legislation to encourage health professionals to serve in health manpower shortage areas was delayed by several factors, including the 1971 wage-price freeze and the Nixon Administration cutback in Federal employment. Consequently, full operation of the program was not achieved until July 1972. By the fall of that year, health personnel serving health manpower shortage areas totalled 288, including 152 doctors, 20 dentists, and 116 other health personnel.[5]

However, the House Interstate and Foreign Commerce Committee report on the 1972 legislation stated that as many as 5,000 U.S. communities still possessed no health care services.[6] As a result, the committee noted:

> Clearly, the job of meeting the needs of critical health manpower shortage areas has merely been begun and there is

---

[4] U.S. Congress. Senate Committee on Labor and Public Welfare. Emergency Health Personnel Act Amendments of 1972. A Report to Accompany S. 3858. Washington, U.S. Government Printing Office. 1972 (92d Congress. 2d session. S. Rept. No. 92–1062). p. 2.

[5] U.S. Congress. House Committee on Interstate and Foreign Commerce. Emergency Health Personnel Act Amendments of 1972: a Report to Accompany H.R. 16755. Washington. U.S. Government Printing Office. 1972 (92d Congress. 2d session. H. Rept. No. 92–1547). p. 4.

[6] Ibid.

a need for more vigorous identification of these areas and assistance to them as well as an expansion of the program.[7]

Debate on the 1972 legislation indicated strong congressional support for extending the NHSC. The Administration opposed consideration of the legislation because the current program established by Public Law 91–623 as well as other health programs was under review. It proposed to complete this review and make recommendations at the time of the submission of the President's Budget for fiscal year 1974. Congress, however, disagreed with the Administration's position, and enacted Public Law 92–585 to revise the Corps.

Public Law 92–585 officially authorized the NHSC, staffed by officers of the Regular and Reserve Corps of the PHS and other personnel as the Secretary of HEW designated, to provide health care services to persons residing in "critical health manpower shortage" areas. The Act provided that the Secretary of HEW (1) designate those areas which he determined to have critical health manpower shortages; (2) provide assistance to persons seeking assignment of Corps personnel to such designated areas; and (3) conduct such information programs in designated areas as may be necessary to inform the public and private entities serving those areas of the assistance available under the program. P.L. 92–585 also required the Secretary to conduct recruiting programs for the Corps at medical and nursing schools, other schools of the health professions, and training centers for the allied health professions.

The 1972 Act also established a Public Health and NHSC Scholarship Training Program to obtain trained physicians, dentists, nurses, and other health-related specialists for the NHSC and other units of the PHS. The Act authorized scholarships for health personnel studying for professional degrees who agreed to serve one year on active duty in a health manpower shortage area for each year of scholarship assistance.

c. Public Law 94–484, the Health Professions Educational Assistance Act of 1976

The legislative authority for the NHSC and its scholarship program expired on June 30, 1974. Public Law 93–385 extended the scholarship authority for fiscal year 1975. Public Law 94–63, Public Health Service Amendments of 1975, extended the authority for the NHSC program for two years for fiscal years 1975 and 1976. Congress later enacted Public Law 94–484, the Health Professions Educational Assistance Act of 1976, which continued the authority for the Corps through fiscal year 1977, and extended its scholarship program for fiscal years 1975 through 1977. The Act also revised health professions programs, including the Corps and its scholarship program, for three years through fiscal year 1980.

Despite significant increases in the total supply of health professionals nationwide, the geographic maldistribution of health manpower had deepened by 1975. Dr. Malcolm Todd, then-president of the American Medical Association summarized the situation:

> * * * to say we're eliminating the shortage of physicians is playing with words * * * It won't make any difference if

[7] Ibid.

> we do have 440,000 physicians in 1980 because they won't be where we need them. Unless we can come up with acceptable incentives for rural practice and inner city practice, we're going to have the same [distribution] problem in 1980 that we do now.[8]

In the mid-1970's, health manpower remained unevenly distributed by region and by demographic units within regions. For example, in 1974, the Northeast and Pacific regions of the United States had, on a per capital basis, over 50 percent more physicians than did Midwestern and Southeastern regions.[9] Further, on a national basis, the physician population ratio in urban areas was 170 physicians per 100,000 population, more than twice the non-urban ratio of 80 per 100,000.[10] In addition, in 35 States, rural areas had less than one-half of the per capita physician supply or urban areas. In 14 States, rural areas had less than one-third the urban supply.[11] The House Interstate and Foreign Commerce Committee, in its report on the 1976 legislation, noted the Corps and its scholarship program:

> * * * represent the most effective legislative mechanism ever developed by the Congress in attempts to solve the growing problem of geographic maldistribution of health professionals in the United States * * *[12]

According to the House report, the Corps had developed an effective recruitment program for health personnel especially physicians. For example, the Corps had increased its recruitment of physicians and dentists from 14 in 1971 to over 300 in 1975. In addition, by 1975, the Corps had approved 443 sites for Corps assistance, and placed 405 physicians, dentists, nurses and other health professionals in 196 communities in 40 States. Approximately 85 percent of the practices were in rural areas.[13] The House Commerce Committee added that it considered the program's potential such that:

> * * * if adequate funding continues, it will serve to attract several thousand health professionals to provide much needed care to medically underserved populations in the foreseeable future.[14]

The Committee noted that the proposed legislation would substantially revise existing provisions of the NHSC program:

> * * * to make it more attractive to medically underserved populations and potential NHSC participants to encourage Corps personnel to remain in areas with medically underserved populations following their service commitments.[15]

As a result, Congress enacted Public Law 94–484 which included several provisions to strengthen and enlarge the Corps and its scholarship programs. For example, the Act increased authorizations for the

---

[8] U.S. Congress. House. Committee on Interstate and Foreign Commerce. Health Manpower Act of 1975; A Report to Accompany H.R. 5546. Washington, U.S. Government Printing Office, 1975 (94th Congress, 1st session, H. Rept. No. 94–266), p. 22.
[9] Ibid.
[10] Ibid., p. 24.
[11] Ibid.
[12] Ibid., p. 29.
[13] Ibid., p. 28.
[14] Ibid., p. 29.
[15] Ibid.

two programs. NHSC authorizations were raised from $34 million in fiscal year 1977 to $47 million in fiscal year 1978, $57 million in fiscal year 1979, and $70 million in fiscal year 1980. Authorizations for the NHSC scholarship program were increased from $40 million in fiscal year 1977 to $75 million in fiscal year 1978, $140 million in fiscal year 1979, and $200 million in fiscal year 1980.

Amendments to the Corps program by Public Law 94–484 included redefining health manpower shortage areas. In addition to designating rural or urban geographic areas with health manpower shortages, the Act provided that the Secreary of HEW could designate population groups which he determined had a shortage, or a public or nonprofit private medical facility or other public health entity which had a shortage.

The 1976 Act also amended the NHSC scholarship program. It expanded eligibility for the program to other types of health professionals such as physician assistants, nurse practitioners, and expanded function dental auxiliaries who, if needed by the Corps, could receive awards. Public Law 94–484 provided that funds appropriated for scholarships be earmarked so that at least 81 percent be awarded to medical and osteopathic students, and at least nine percent to dentistry, with the remaining 10 percent allocated to other professions. In addition, the Act also authorized special project grants to former Corps members who agreed to enter into private practice in a health manpower shortage area for at least one year. These grants were to be used to assist the individual in meeting the costs of a beginning practice.

d. NHSC program

(1) Authorizations/appropriations

Authorizations increased from $10 million in fiscal year 1971 to $82.5 million in fiscal year 1980 for the NHSC program. At the same time, appropriations increased from $3 million in fiscal year 1971 to $70.5 million in fiscal year 1980. Since 1971, total appropriations for the Corps equalled $277 million.

TABLE 3.—NHSC PROGRAM AUTHORIZATION/APPROPRIATIONS, FISCAL YEARS 1971–80

[In millions of dollars]

Year	Authorizations	Appropriations
1971	10.0	3.0
1972	20.0	12.5
1973	30.0	11.0
1974	25.0	13.0
1975	16.0	15.0
1976	30.0	24.0
1977	34.0	25.0
1978	47.0	40.0
1979	64.0	63.0
1980	82.5	70.5
Total	358.5	277.0

Source: Phone conversation with Office of Financial Management, Department of Health and Human Services (DHHS), Health Services Administration (HSA), April 1980.

NHSC personnel are assigned to practice in health manpower shortage areas designated as Corps sites. In 1972, 181 Corps per-

sonnel served 94 such sites. By 1979, there were 1,824 Corps personnel serving 875 sites. This represents a 900 percent increase in the number of personnel practicing in the Corps between 1972 and 1979. The first NHSC scholarship recipients began serving their obligation in 1976 when 17 were assigned to Corps sites. At that time, scholarship recipients represented 2.8 percent of NHSC personnel placed at such sites. By 1979, that percentage rose to 38 percent when 696 scholarship recipients began practicing at Corps sites.

TABLE 4.—NHSC FIELD STRENGTH

Year	Number of personnel	Number and percentage of scholarship recipients		Corps sites
		Number	Percentage	
1972	181			94
1973	330			183
1974	392			193
1975	488			248
1976	596	17	2.8	331
1977	690	118	17.0	398
1978	1,289	381	29.5	668
1979	1,824	696	38.0	875

Source: Phone conversation with NHSC Program Office, DHHS, HSA, Bureau of Community Health Services (BCHS) May 1980.

(3) *NHSC retention rates*

NHSC retention rates represent the number of personnel who choose to extend their service with the Corps after their obligation is completed, or convert to private practice at their or another site. These rates increased from three percent in 1973 to 53 percent in 1979.

TABLE 5.—*NHSC Retention Rates*

Year:	*Percent*	Year:	*Percent*
1973	3	1977	48
1974	20	1978	48
1975	30	1979	53
1976	38		

Source: Phone conversation with NHSC Program Office, DHHS, HSA, BCHS, May 1980.

Despite increasing retention rates, a 1978 General Accounting Office report, *Progress and Problems in Improving the Availability of Primary Care Providers in Underserved Areas*, noted that, prior to 1976, many Corps physicians chose not to remain in practice in health manpower shortage areas. Although the Corps had increased the availability of physician services in these areas, the GAO report indicated that relatively few of these physicians remained in a shortage area in private practice after completing Federal service.[20] GAO determined that, from a total of approximately 800 NHSC physicians recruited through July 1976, only 42 remained in shortage areas in private practice or planned to do so.[21] According to the GAO report, NHSC officials attributed this low figure to recruiting policies followed before fiscal year 1974. Most physicians hired in the early 1970's had draft obligations, and many had not completed their residency training.[22]

[20] U.S. General Accounting Office. "Progress and Problems In Improving The Availability of Primary Care Providers in Underserved Areas"; Report to the Congress by the Comptroller General of the United States. [Washington] 1978, p. 30.
[21] Ibid.
[22] Ibid.

e. NHSC scholarship program

(1) Authorizations/appropriations

NHSC scholarships authorization levels increased from $3 million in fiscal year 1974, the program's first year of operation, to $200 million in fiscal year 1980. At the same time, appropriations rose from $3 million to $85.5 million. Total appropriations for the Scholarship program equaled $331 milion.

TABLE 6.—NHSC SCHOLARSHIP PROGRAM AUTHORIZATIONS/APPROPRIATIONS, FISCAL YEARS 1974–80

[In millions of dollars]

Year	Authorization	Appropriation
1974	3	3.0
1975	40	22.5
1976	40	22.5
Transition quarter	(1)	22.5
1977	40	40.0
1978	75	60.0
1979	140	75.0
1980	200	85.5
Total	538	331.0

[1] There was a general authorization with no dollar figures for the NHSC scholarship program for the transition quarter

Source: Phone conversation with Office of Financial Management, DHHS, Health Resources Administration (HRA). Bureau of Health Manpower (BHM), April 1980.

(2) Applications for NHSC scholarships

Between academic years 1973–74 and 1979–80, applications for NHSC scholarships rose from 1,590 to 6,568, a 313.1 percent increase. The majority of applications, 16,874, or 64.7 percent, came from allopathic medical students.

TABLE 7.—NUMBER OF APPLICATIONS FOR INITIAL NATIONAL HEALTH SERVICE CORPS SCHOLARSHIP AWARD BY DISIPLINE AND ACADEMIC YEAR, 1973–74 TO 1979–80

Discipline	Total	1973–74	1974–75	1975–76	1976–77	1977–78	1978–79	1979–80
Total all disciplines	26,901	1,590	2,780	2,818	3,492	3,488	5,364	7,399
Alleopathy	16,874	1,352	2,419	1,913	2,506	2,259	2,946	3,479
Osteopathy	2,488	238	361	344	374	305	389	447
Dentistry	4,271	----	----	561	612	392	1,311	1,395
Nursing (baccalaureate)	971	----	----	----	----	159	312	500
Public health nursing	45	----	----	----	----	14	13	18
Nursing midwifery	44	----	----	----	----	15	15	14
Nurse practitioner training	115	----	----	----	----	29	27	59
Public health nutrition	109	----	----	----	----	31	31	47
Medical social work	307	----	----	----	----	194	113	----
Speech pathology and Audiology	152	----	----	----	----	90	62	----
Veterinary medicine	246	----	----	----	----	----	----	246
Optometry	3	----	----	----	----	----	----	3
Podiatry	344	----	----	----	----	----	----	344
Pharmacy	16	----	----	----	----	----	----	16
Ineligible	976	----	----	----	----	----	145	831

Source: (1) NHSC scholarship program 1978–79 report to Congress, DHEW, HRA, BHM. (2) 1977–78 to 1979–80 data provided by NHSC scholarship program, DHHS, HRA, BHM.

(3) NHSC scholarship awards

(a) Number of awards

NHSC Scholarship awards rose from 372 in academic year 1973–74 to 6,408 in academic year 1979–80. During this time, almost 80 percent

of the scholarships were awarded to allopathic medical students. Of the 6,408 awards made in academic year 1979–80, 4,029 were continuations and 2,379 were new awards.

TABLE 8.—NATIONAL HEALTH SERVICE CORPS SCHOLARSHIP AWARDS ACADEMIC YEARS 1973–74 TO 1979–80

Academic year	Total	1973–74	1974–75	1975–76	1976–77	1977–78	1978–79	1979–80
Total awards	22, 670	372	1, 864	2, 552	2, 649	3, 571	5, 254	6, 408
Allopathic medicine	18, 085	343	1, 664	2, 209	2, 240	2, 953	4, 012	4, 764
Osteopathic medicine	2, 455	29	200	295	335	443	543	610
Dentistry	1, 250			48	74	119	441	568
Nursing (baccalaureate)	386					40	159	187
Public health nursing	43					13	10	20
Nurse midwifery	38					8	12	18
Nurse practitioner training	88					16	18	54
Public health nutrition	93					19	25	49
Medical social work	66					40	18	8
Speech pathology/audiology	47					20	16	11
Veterinary medicine	4							4
Optometry	3							3
Podiatry	106							106
Pharmacy	6							6
New awards	11, 446	372	1, 499	874	885	2, 090	3, 347	2, 379
Allopathic medicine	8, 822	343	1, 328	717	729	1, 596	2, 390	1, 719
Osteopathic medicine	1, 156	29	171	109	106	239	314	188
Dentistry	769			48	50	99	387	185
Nursing (baccalaureate)	279					40	159	80
Public health nursing	34					13	10	11
Nursing midwifery	29					8	12	9
Nurse practitioner training	74					16	18	40
Public health nutrition	72					19	25	28
Medical social work	57					40	17	
Speech Pathology/audiology	35					20	15	
Veterinary medicine	4							4
Optometry	3							3
Podiatry	106							106
Pharmacy	6							6
Continuation awards	11, 224		365	1, 678	1, 764	1, 481	1, 907	4, 029
Allopathic medicine	9, 263		336	1, 492	1, 511	1, 257	1, 622	3, 045
Osteopathic medicine	1, 299		29	186	229	204	229	422
Dentistry	481				24	20	54	383
Nursing (baccalaureate)	107							107
Public health nursing	9							9
Nurse midwifery	9							9
Nurse practitioner training	14							14
Public health nutrition	21							21
Medical social work	9						1	8
Speech pathology/audiology	12						1	11
Veterinary medicine								
Optometry								
Podiatry								
Pharmacy								

Source: NHSC scholarship program, DHHS, HRA, BHM.

(b) Medical and osteopathic schools with the most scholarship recipients

Between academic years 1973–74 and 1979–80, Meharry Medical College School of Medicine in Tennessee had 368 NHSC scholarship recipients, more than any other U.S. medical or osteopathic school. The Meharry scholarships represented two percent of the 18,085 awards made to medical students during those years. Scholarships for ten schools (see table below) represented 12 percent of the 20,540 awards made to medical and osteopathic students between academic years 1973–74 and 1979–80.

TABLE 9.—*Medical and osteopathic schools with the most award recipients, academic years 1973–74 through 1978–79*

Meharry Medical College School of Medicine, Tenn	368
Georgetown University School of Medicine, District of Columbia	313
Kansas City College of Osteopathic Medicine, Mo	251
Howard University School of Medicine, District of Columbia	249
George Washington University School of Medicine, District of Columba	242
Loma Linda University School of Medicine, Calif	225
Medical College of Thomas Jefferson University, Pa	216
Tufts University School of Medicine, Mass	210
Philadelphia College of Osteopathic Medicine, Pa	170
Temple University School of Medicine, Pa	169

Source: Phone conversation with NHSC Scholarship Program Office, DHHS, HRA, BHM, April 1980.

Forty-five percent of Meharry's medical students were receiving NHSC scholarship support in academic year 1979–80; the highest rate of student participation of all medical osteopathic schools in the Nation. Other schools with high rates of participation included: Howard University School of Medicine, 29 percent; Tufts University School of Medicine, 25 percent; Loma Linda University School of Medicine, 22 percent; Kirksville College of Osteopathic Medicine, 19 percent; Kansas City College of Osteopathic Medicine, 18 percent; Jefferson Medical College, 15 percent; and University of Puerto Rico School of Medicine, 15 percent.[23]

(c) Minorities and women

Between academic years 1973–74 and 1977–78, a significant share of the 4,566 new scholarships awarded to medical students went to minorities. Although Black students comprised only 6.1 percent of all U.S. medical students, they accounted for 19.5 percent of NHSC scholarship recipients. About 3.9 percent of scholarship recipients were Hispanic, even though they represented only 2.7 percent of all medical students. American Indians totaled only 0.3 percent of all medical students, but equalled 1.2 percent of NHSC recipients. Women—20 percent of all medical students—received 22.5 percent of the new awards during this same period.[24]

(*4*) *Fulfilling the service obligation*

(a) Deferment

Ass of January 1, 1980, almost 60 percent (6,169) of the 11,446 students awarded scholarships since academic year 1973–74 were still pursuing professional degrees. Medical, osteopathic and dental scholarship recipients deferred for postgraduate training totaled 2,470.[25]

(b) Number of scholarship recipients who fulfill their service obligation through private practice

A NHSC scholarship recipient can fulfill his service obligation by entering private practice in a designated health manpower short-

[23] More Students Compete for Fewer Awards. Health Resources News, vol. 6, December 1979: p. 1.

[24] Training Health Manpower for Underserved Areas 1973–79—A Report to the People on National Health Service Corps Scholarship Program. Bureau of Health Manpower, Department of Health, Education and Welfare, 1979, p. 5.

[25] Phone conversation with NHSC Scholarship Program Office, DHHS, HRA, BHM, April 1980.

age area which has a priority for the assignment of corps members and can financially support the practice.

For 1980, three scholarship recipients chose to fulfill their service obligation through private practice. Prior to that time, no scholarship recipient had chosen this alternative.[26]

(c) Attrition

Between May 1973 and September 1979, 97 recipients defaulted on their service obligation due to academic failure, disciplinary dismissal, or voluntary withdrawal from school. During that same time, there were 666 scholarship recipients who obtained a professional degree but failed to begin or complete their service obligation. Of that 666, 61 have paid back the full amount of their indebtedness. Forty scholarship recipients were granted waivers due to death, physical or mental disability, or severe financial problems. The remainder are currently repaying their debts or arranging for repayment.[27]

d. Health manpower shortage areas

As of December 31, 1979, 5,149 health manpower shortage areas had been designated in the United States. These areas were designated according to the following types: (1) primary care—1,710; (2) dental care—861; (3) vision care—248; (4) podiatric care—1,404; (5) pharmacy—139; (6) veterinary care—631; and (7) psychiatric care—156.[28]

2. Need

a. Geographic maldistribution

This committee continues to be concerned about the problem of geographic maldistribution. The NHSC and its scholarship program were established to encourage health personnel to practice in health manpower shortage areas. Legislation authorizing these programs represented congressional efforts to alleviate the shortages of health personnel in certain areas of the country caused by the geographic maldistribution of health professionals. Although the two programs have increased the availability of health services in shortage areas, the problem of geographic maldistribution persists in the country today.

Health personnel remain unevenly distributed across regions of the country, the States, between urban/rural areas, and within metropolitan areas. With regard to physicians specifically, Table 10 indicates that active physicians have increased in number from 277,575

[26] Phone conversation with NHSC Program Office, DHHS, HSA, BCHS, May 1980.
[27] Phone conversation with NHSC Scholarship Program Office, DHHS, HRA, BHM, May 1980.
[28] Phone conversation with Shortage Area Designation Staff, DHHS, HRA, BHM, April 1980.

in 1965 to 363,290 in 1975 to an estimated 416,680 in 1979 The ratio of active physicians per 100,000 population has increased during this same period from 139.9 in 1965, to 166.7 in 1975, and to 185.1 in 1979.

TABLE 10.—TOTAL AND ACTIVE PHYSICIANS (H.D.'S) AND PHYSICIAN-TO-POPULATION RATIOS: DEC. 31, SELECTED YEARS 1950–77, AND ADJUSTED DATA FOR 1975, 1977, AND 1979

Year	Number of physicians [1]		Total population (thousands) [2]	Physicians per 100,000 population		Active non-Federal physicians	Civilian population (thousands) [3]	Active non-Federal, physicians per 100,000 civilian population
	Total	Active		Total	Active			
1950	219,997	208,997	156,024	141.0	134.0	193,900	153,640	126.2
1955	241,711	228,553	169,959	142.2	134.5	213,000	167,043	127.5
1960	260,484	247,257	184,896	140.9	133.7	230,200	182,351	126.2
1965	292,088	277,575	198,357	147.3	139.9	254,761	195,451	130.3
1970	334,028	310,845	209,096	159.7	148.7	281,344	206,129	136.5
1975	393,742	340,280	217,966	180.6	156.1	312,089	215,828	144.6
1977	421,278	363,619	221,419	190.3	164.2	343,693	219,300	156.7
1975 [4]	393,742	363,290	217,966	180.6	166.7	335,100	215,828	155.3
1977 [4]	421,278	391,180	221,419	190.3	176.7	371,250	219,300	169.3
1979 [4 5]	450,800	416,680	225,099	200.3	185.1	396,680	223,012	177.9

[1] Includes physicians in Federal service; also includes physicians in U.S. possessions, i.e., Puerto Rico, Virgin Islands Canal Zone, and Pacific Islands.
[2] Total population includes civilian population in U.S. possessions.
[3] Includes civilian population in U.S. possessions.
[4] These numbers of active physicians are adjusted to include about 90 percent of those either with unknown address or not classified as to status or activity by the American Medical Association.
[5] Total and active physician counts for 1979 are estimated.

Source: Unpublished data, U.S. Department of Health and Human Services, Health Resources Administration, Bureau of Health Manpower, Division of Manpower Analysis, January 1980.
Data for 1950 through 1960 from U.S. Department of Health, Education, and Welfare, National Center for Health Statistics. "Health Resources Statistics 1965," PHS publication No. 1509, 1966.
Data for 1965 through 1977 (unadjusted) from American Medical Association, Center for Health Services Research and Development. "Physician Distribution and Medical Licensure in the U.S., 1977." Also prior annual issues.
Adjusted data for 1975, 1977, and 1979 from Health Resources Administration, Bureau of Health Manpower, Division of Manpower Analysis.
U.S. Bureau of the Census. Current Population Report P–25, Nos. 336, 438, 542, 603, and 812.

Table 11 details the distribution of non-Federal physicians across the States. According to Department of Health and Human Services (DHHS) estimates, the ratio of non-Federal physicians active in patient care per 100,000 population was 165.3 for the Nation as a whole in 1979. Despite substantial increases in the supply of physicians since 1965, this ratio varied significantly across the regions and States in 1979. For the regions of the country, this ratio ranged from 145.7 in the South and 146.2 in the North Central States to 183.6 in the West and 201.0 in the Northeast. For the States, the ratio ranged from 97.5 in South Dakota, to 230.4 in New York, and to 446.3 in the District of Columbia.

TABLE 11.—ADJUSTED SUPPLY OF ACTIVE NON-FEDERAL PHYSICIANS (M.D.'S) AND NON-FEDERAL PHYSICIANS ACTIVE IN PATIENT CARE, AND RESPECTIVE PHYSICIAN-TO-POPULATION RATIOS, BY REGION, DIVISION, AND STATE: DEC. 31, 1979[1]

Geographic area	All active non-Federal physicians	Active non-Federal physicians in patient care	Civilian population July 1, 1979 (thousands)[2]	Active non-Federal physicians per 100,000 civilian population	Non-Federal physicians active in patient care per 100,000 civilian population
United States[3]	393,103	361,083	218,497	179.9	165.3
Northeast	108,511	98,275	48,896	221.9	201.0
New England	28,192	25,251	12,244	230.2	206.2
Connecticut	7,464	6,675	3,101	240.7	215.2
Maine	1,648	1,553	1,087	151.6	142.9
Massachusetts	14,610	12,914	5,758	253.7	224.3
New Hampshire	1,466	1,354	883	166.0	153.3
Rhode Island	1,962	1,821	928	211.4	196.2
Vermont	1,042	934	487	214.0	191.8
Middle Atlantic	80,319	73,024	36,652	219.1	199.2
New Jersey	13,361	12,382	7,306	182.9	169.5
New York	45,126	40,613	17,624	256.0	230.4
Pennsylvania	21,832	20,029	11,722	186.2	170.9
North Central	91,900	85,171	58,266	157.7	146.2
East North Central	65,573	60,957	41,223	159.1	147.9
Illinois	20,169	18,566	11,193	180.2	165.9
Indiana	6,948	6,517	5,395	128.8	120.8
Michigan	14,040	13,063	9,197	152.7	142.0
Ohio	17,167	16,056	10,719	160.1	149.8
Wisconsin	7,249	6,755	4,719	153.6	143.1
West North Central	26,327	24,214	17,043	154.5	142.1
Iowa	3,613	3,361	2,902	124.5	115.8
Kansas	3,556	3,271	2,344	151.7	139.5
Minnesota	7,620	7,042	4,058	187.8	173.5
Missouri	7,700	6,966	4,848	158.8	143.7
Nebraska	2,314	2,125	1,562	148.1	136.0
North Dakota	824	783	646	127.5	121.2
South Dakota	700	666	683	102.5	97.5
South	111,694	103,060	70,708	158.0	145.7
South Atlantic	61,208	56,096	34,452	177.7	162.8
Delaware	962	906	577	166.7	157.0
District of Columbia	3,398	2,892	648	524.4	446.3
Florida	16,369	15,359	8,765	186.7	175.2
Georgia	7,270	6,812	5,055	143.8	134.8
Maryland	9,952	8,719	4,107	242.3	212.3
North Carolina	8,393	7,602	5,511	152.3	137.9
South Carolina	3,778	3,511	2,366	131.8	122.5
Virginia	8,477	7,842	5,046	168.0	155.4
West Virginia	2,609	2,453	1,877	139.0	130.7
East South Central	18,485	17,214	13,983	132.2	123.1
Alabama	4,629	4,297	3,766	123.6	114.7
Kentucky	4,655	4,331	3,492	133.3	124.0
Mississippi	2,562	2,455	2,384	107.4	102.9
Tennessee	6,639	6,131	4,355	152.3	140.6
West South Central	32,001	29,750	22,278	143.7	133.6
Arkansas	2,567	2,419	2,178	118.3	111.5
Louisiana	5,828	5,436	3,993	145.9	136.1
Oklahoma	3,690	3,489	2,861	128.9	121.9
Texas	19,916	18,406	13,246	150.3	139.0
West	80,998	74,577	40,628	199.4	183.6
Mountain	17,288	16,047	10,560	163.7	152.0
Arizona	4,398	4,097	2,424	181.4	169.0
Colorado	5,437	4,976	2,731	199.1	182.2
Idaho	1,005	966	899	111.8	107.4

TABLE 11.—ADJUSTED SUPPLY OF ACTIVE NON-FEDERAL PHYSICIANS (M.D.'S) AND NON-FEDERAL PHYSICIANS ACTIVE IN PATIENT CARE, AND RESPECTIVE PHYSICIAN-TO-POPULATION RATIOS, BY REGION, DIVISION, AND STATE: DEC. 31, 1979 [1]—Continued

Geographic area	All active non-Federal physicians	Active non-Federal physicians in patient care	Civilian population July 1, 1979 (thousands) [2]	Active non-Federal physicians per 100,000 civilian population	Non-Federal physicians active in patient care per 100,000 civilian population
Montana	1,017	982	781	130.2	125.7
Nevada	909	861	693	131.2	124.2
New Mexico	1,786	1,631	1,225	145.8	133.1
Utah	2,270	2,092	1,361	166.8	153.7
Wyoming	466	442	446	104.5	99.1
Pacific	63,710	58,530	30,068	211.9	194.7
Alaska	460	433	383	120.1	113.0
California	50,334	46,207	22,428	224.4	206.0
Hawaii	1,735	1,591	857	202.4	185.6
Oregon	4,429	4,121	2,524	175.5	163.3
Washington	6,752	6,178	3,876	173.7	159.4

[1] Numbers are adjusted to include most physicians whose address or activity status are unknown.
[2] State population figures may not add to totals due to independent rounding.
[3] Excludes counts of physicians and population in U.S. possessions.

Source: Unpublished data, U.S. Department of Health and Human Services, Health Resources Administration, Bureau of Health Manpower, January 1980.

An examination of data with regard to the distribution of physicians between urban and rural areas reveals a similarly uneven distribution of these professions. Table 12 compares ratios of non-Federal physicians involved in patient care activities per 100,000 population by metropolitan/nonmetropolitan classification for two years, 1967 and 1977. For the two smallest non-metropolitan county categories, these ratios declined slightly between 1967 and 1977. All other categories increased, with the metropolitan category 50,000–499,999 showing the largest percentage increase in physician/population ratios during the ten-year period.

TABLE 12.—DISTRIBUTION OF NON-FEDERAL PHYSICIANS IN PATIENT-CARE ACTIVITIES BY DEMOGRAPHIC COUNTY CLASSIFICATION, 1967–77

Demographic county classification	Non-Federal physicians in patient-care per 100,000 residents		Percentage increase/ decrease 1967–77
	1967	1977	
Total	126	147	+16.7
Nonmetropolitan:			
Less than 10,000	44	43	−2.3
10,000 to 24,999	54	53	−1.9
25,000 to 49,999	69	78	+13.0
50,000 or more	87	100	+14.9
Potential metropolitan	107	125	+16.8
Metropolitan:			
50,000 to 499,999	112	141	+25.9
500,000 to 999,999	136	153	+12.5
1,000,000 to 4,999,999	159	182	+14.5
5,000,000 or more	195	209	+7.2

Source: "Physician Distribution and Medical Licensure in the United States, 1977." American Medical Association, 1979.

Despite the abundance of physicians in metropolitan areas relative to nonmetropolitan rural areas, within these same metropolitan areas there often exist large disparities in the distribution of physicians between inner city and suburban areas. Donald Dewey has studied

the changing distribution of physicians in the Chicago metropolitan area, and his research has provided some of the most comprehensive data available on the changing distribution of physicians in metropolitan areas. An early study by Dr. Dewey found that between 1950 and 1970 physicians moved from areas with, or changing toward, high concentrations of black and poor populations and into areas with concentrations of affluent populations, hospital facilities and retail shopping centers.[16] The physician/population ratios of the ten most affluent communities in the Chicago standard metropolitan statistical area (SMSA) rose from 178 per 100,000 in 1950 to 210 per 100,000 in 1970. The same ratio for the ten most impoverished communities fell from 96 per 100,000 to 26 per 100,000.

A later study by Dr. Dewey analyzed the effects of the physician's age on the location of practice.[17] This study showed that younger doctors chose locations in the wealthier suburbs. The study found that the average age of physicians in the ten poorest urban neighborhoods rose from 57.8 to 62.4 between 1950 and 1970, while the average age of physicians in the ten wealthiest communities remained at 48.3 throughout the study period. In 1970, only 16 percent of the physicians in the poor neighborhoods were under 46 years of age, while almost 30 percent were 65 years or older. In the same year, nearly 40 percent of the physicians in the wealthiest communities were under 46 years, while only 10 percent were 65 years or older.

A recent study by Dr. Dewey of the impact of foreign medical graduates (FMGs) on the maldistribution of physicians in the Chicago area revealed that practice patterns and location of FMGs are not very different from the practice patterns and location of U.S. medical school graduates.[18] The geographic distribution, age-specific distributions, and medical and specialty practice patterns of FMGs do little to alleviate the shortage of physicians in the medically underserved areas of Chicago.

Data from this last study by Dr. Dewey provided updated information on trends in the distribution of physicians in the Chicago area in the 1970s. According to Dr. Dewey, analysis of the growth, types of practice, age, and geographic distribution of office-based U.S. medical school graduates and total physicians revealed that the trends of the fifties and sixties were continuing in the seventies. In addition, Dr. Dewey found that physicians left the city faster than the population and that they continued to prefer to practice in white high- and middle-income suburbs.

In a briefing on "Forthcoming Demographic Changes and the Health Care System," Peter Morrison of the Rand Corporation also noted the increasing concentration of disadvantaged people in large central cities.[19] In addition, he commented upon the Nation's changing pattern of settlement, altering the geography of the demand for health services. According to Mr. Morrison, since 1970, large numbers of per-

[16] Donald Dewey, "Where the Doctors Have Gone," Illinois Regional Medical Program, Chicago Regional Hospital Study, Chicago, 1975.

[17] Donald Dewey, "A Survey and Analysis of the changing Age Distribution of Private Practice Physicians in Metropolitan Chicago, 1950–1970." Paper presented to the 20th Annual meeting of the Association of American Geographers, Seattle, Wash., 1974.

[18] Donald Dewey, "Foreign Medical Graduates: Sources, Growth, Geographic Distribution and Locational Factors in Metropolitan Chicago," 1950–1974, DePaul University 1979.

[19] A briefing for Congressional staff, arranged by the Population Resource Center in cooperation with the Population Association of America's Public Affairs Committee. This briefing took place on Sept. 17, 1979, in Washington, D.C.

sons have changed their minds about where they prefer to live. A trend toward the dispersal of the Nation's population from large communities has been revealed in several ways.

First, there has been a notable shift away from large metropolitan centers to smaller ones. In 1970, the average American resided in a place that had 524,000 inhabitants. By 1975, the population of this hypothetical place was down to 455,000—a 13-percent reduction in only five years. People are favoring the smaller metropolitan areas, such as Lincoln, Nebraska, Lafayette, Louisiana Tyler, Texas, and Colorado Springs.

Two other forms of dispersal are also under way. One is "spillover"—an extension of the traditional pattern of suburban growth to areas beyond the metropolitan fringe. This is where many smaller satellite cities are forming 50 or 100 miles out from a major metropolitan area.

And there also is a new growth resurgence in truly remote nonmetropolitan areas. This is the so-called "rural renaissance," occurring in such places as northern New Hampshire, upper Michigan, and the Ozarks. The number of migrants moving there is not very large, but then the rural destinations are not very large either, so the arrival of a few people can make a substantial impact.

We do not know how long this deconcentration of settlement patterns will continue. It may persist through the decade of the 1980s—or it may cease. Its persistence will pose several issues about health service delivery in the growing nonmetropolitan areas.

The geographic maldistribution of health professionals will remain one of the Nation's health manpower problems in the future. The Administration has testified that in 1990 up to 16,400 additional physicians and mid-level professionals could be needed in medically underserved areas and facilities: 7,500 in rural areas; 5,200 in inner-cities; and 3,700 in prisons and mental institutions.

According to Table 12, there is evidence of some increase in the number of physicians moving into smaller cities and towns over the past decade, with most of the increase in physician/population ratios occurring in medium-sized rural towns. As Table 12 also indicates, few physicians, however, have chosen to locate in the most underserved areas—largely poor or highly rural communities with few health care resources.

In 1976, the Congress noted several factors which might explain patterns of the geographic distribution of physicians and other health personnel throughout the country. These include economic considerations, that is, levels of reimbursement and income expected from a given practice location; third-party payments for physician services are often less in rural or economically deprived areas than in affluent, suburban regions. Other factors often mentioned as influencing practice location include the type of community in which the physician was born or lived before attending medical school; the location of the medical school, the location of residency training; social, cultural, and environmental characteristics of a community; and the proximity of professional colleagues and health facilities. The relative importance, however, of any one of these factors in explaining a physician's choice for practice location remains unknown.

b. Failure of loan forgiveness programs

The Committee recognizes that there are those who believe that a program of loan forgiveness would be sufficient to recruit adequate numbers of young physicians to shortage areas. Unfortunately, there is little evidence that such a program has worked in the past, or is likely to do so in the future.

With respect to previous experience with loan forgiveness programs, the GAO reported in 1975 that, while 30,000 health professionals were eligible for loan forgiveness, ". . . only 62 physicians and 121 dentists had obtained cancellations of a portion of these loans for practice in a designated shortage area. Further, of 167 of those responding to a General Accounting Office questionnaire, 137 stated they would have chosen the same location for their practice, even if the loan cancellation provisions had not been available. Only 11 stated definitely that they would not have located where they did without the benefit of loan cancellation." GAO concluded that the loan forgiveness program did not appear to have a significant impact on influencing medical and dental school graduates to locate their practices in shortage areas.

In considering the possible effectiveness of loan forgiveness programs, the Committee requested the Congressional Budget Office to develop projections of future physician indebtedness and incomes. These projections would appear to confirm the view that loan forgiveness programs do not create a financial incentive to seek cancellation of some indebtedness by serving in shortage areas.

3. Proposed legislation

The purpose of the National Health Service Corps (NHSC) is to insure that health professionals, particularly primary care physicians, are available to provide health services "in or to a health manpower shortage area". A health manpower shortage area (HMSA) includes (1) an urban or rural area which has a health manpower shortage, (2) a population group which has such a shortage, or (3) a public or nonprofit private medical facility or other public facility which has such a shortage. Based on criteria set forth in Sec. 332(b) of the Public Health Service Act, the Secretary has designated HMSAs and has ranked them according to their relative need for health professionals. Approximately half of the HMSA's have been given a "priority" for the assignment of NHSC members because those areas have the "greatest health manpower shortage".

It is the Committee's view that this designation scheme performs the useful function of indicating those areas, population groups and facilities which have the greatest need for health professionals. The Committee expects, however, that the NHSC will provide health professionals not only to priority HMSA's but to all HMSA's. The NHSC's purpose is more accurately described as being twofold. First, the NHSC is to encourage health professionals, particularly primary care physicians, to settle in communities in all HMSA's and to begin the private practice of their profession. The Committee recognizes that the HMSA's where private practice is viable most often are not the HMSA's with a priority for assignment. But to the extent that the NHSC can encourage a health professional to settle permanently in any HMSA, essential health services will be provided to the residents

of that area. Second, the NHSC is to place health professionals in those HMSA's which have the greatest health manpower shortage and for which there is little realistic expectation that a health professional will settle permanently.

In carrying out these goals the Committee expects the NHSC to commit substantial resources to the recruitment of health professionals, particularly primary care physicians and other primary care providers, who will volunteer for service in the NHSC. These volunteers are more likely to stay in a community, in the NHSC or on their own, over an extended period of time than an individual who is serving in the NHSC only to fulfill his or her NHSC scholarship obligation.

The Committee hopes that appropriations during fiscal years 1981 through 1983 will be sufficient to allow the NHSC to recruit an increasing number of these volunteers and to assign all scholarship recipients who are available for service during these years. If appropriations are not made in such amounts, the Committee expects the NHSC to continue its efforts to encourage scholarship recipients to exercise the private practice option and to maintain those sites which need NHSC asssitance and which are staffed by volunteers or scholarship recipients who want to remain at those sites.

If appropriations are not sufficient to allow the NHSC to bring all scholarship recipients available for service into the NHSC, the Committee expects the Department to develop an equitable method of relieving some of them of their service obligation. This method should assure that those who want to serve have an opportunity to serve.

a. Designation of HMSA's

The Committee received comments on the HMSA designation process alleging that areas have been designated which do not have a shortage of health professionals. Incorrect designations were said to be the result of the Secretary's use of data derived on a county basis. The concern was that county data did not account for health resources which might be available to the residents of one county in a contiguous county.

The Committee could not determine whether the allegations were accurate; however, the Committee does believe that the designation process should be altered to make it more sensitive to such local conditions. Under the Committee's bill the Secretary would refer a proposed designation of an area, population group, or facility to the appropriate health systems agency (HSA). Federal medical facilities would not be subject to this new designation system. If an HSA was not designated, the state health planning and developing agency would perform the HSA's functions. The HSA would review the proposed designation by considering the criteria established under Sec. 332(b) of the Public Health Service Act, the recommendations of the Governor of the state, the comments of all interested persons and of the appropriate health professions societies in the area, the extent to which physicians in that area have been suspended from participation in Medicare and Medicaid, and any other matters the HSA determines are relevant. Upon completion of its review the HSA would approve or disapprove the designation and submit to the Secretary a detailed written statement of the reasons for its decision. The Secretary would

designate in accord with the HSA's decision, unless, within 60 days, the Secretary reviews the HSA's decision and determines that it is "not supported by the criteria established under Sec. 332(b) and the other matters considered by the agency in making its decisions" and submits to the HSA a detailed written statement of the reasons for reversing its determination. The Committee would expect the Secretary to initiate such a review if requested to do so by any individual or entity adversely affected by the HSA decision.

The new designation process will go into effect one year after the date of enactment of the bill to give HSA's the opportunity to develop the capability to perform these new designation responsibilities.

In addition, the Committee would require the Secretary to evaluate the criteria currently used to designate HMSA's to determine if its use has resulted in the designation of areas which do not have a shortage of health professionals. In conducting the evaluation, the Secretary would consider different criteria, including the actual use of health professionals by the residents of an area, to determine if it might be used to improve the designation process. The Secretary would report the result of that evaluation to the Congress within 18 months.

b. Assignment of National Health Service Corps Members

(1) Private placement

Under current law NHSC members are Federal employees, either as officers of the Regular or Reserve Corps of the Public Health Service or as civilian personnel in the Civil Service. The Committee's bill would permit the Secretary to assign an NHSC member to a public or private non-profit health center as an employee of that center to serve subject to the personnel system of that center.

In many instances, public and private entities have sufficient financial resources to pay appropriate salaries to health care providers but cannot recruit them. This new assignment mechanism will better meet their needs and also will remove NHSC members from the federal personnel system and budget. In addition, it will create a new incentive for all public and private entities to maximize their local resources so that NHSC members assigned to them will operate under their personnel systems. There also are many instances where public and private nonprofit entities do not have sufficient financial resources to pay appropriate salaries to health care providers. The Committee's bill would permit the Secretary to make grants to such entities to supplement their financial resources so that they could have NHSC members assigned as their employees. In either case, NHSC members assigned as employees of public or private nonprofit entities would receive incomes equal to the incomes they would receive as NHSC members in the Civil Service. The Secretary would establish the required income by determining the value of the salary and all fringe benefits (including malpractice insurance) available to a member of the NHSC serving in the Civil Service.

The Committee's bill partially insures that NHSC members assigned under this private placement option will be treated equitably with other NHSC members assigned under the Commissioned Corps of the Public Health Service or the Civil Service. The Secretary would be required to prescribe provisions applicable to private placement members so that, if they become officers of the Public Health Service within

one year of completing their NHSC obligation, the time they serve in the NHSC will be treated as time served in the Public Health Service. The Committee recognizes that it would not enable a private placement member to return to the Civil Service under the same equitable conditions. Such an amendment would have been outside the jurisdiction of the Committee.

A public or private nonprofit entity to which an NHSC member is assigned under the private placement option would be subject to the same cost sharing provisions, under section 334 of the Public Health Service Act, as any other entity assigned an NHSC member.

Because the amendment establishing the private placement option changes the terms of the service obligation of scholarship recipients, the amendment would apply only to those scholarship contracts entered into after the date of the enactment of the bill. However, because previously signed scholarship contracts of those individuals who have not begun their service obligation can be changed with their agreement, the Secretary would be required to give them the opportunity to revise their contracts so that they could fulfill their service obligation as a member of the NHSC and an employee of a public or private non-profit health center.

(2) Intergration of NHSC with other Federal programs

The Department's current strategy for the assignment of NHSC members is to assign them to public and private non-profit entities, such as community health centers and migrant health centers, which are receiving other federal funds. While the Committee recognizes that the integration of federal support serves well those communities which do not have adequate financial resources, it discriminates against other communities in HMSA's which have adequate financial resources but cannot recruit health professionals. This strategy also has the unintended effect of encouraging public and private entities with adequate local resources to seek federal financial assistance. The Committee's bill would prohibit the Secretary, in approving applications for the assignment of NHSC members, from disapproving an application from a public or private non-profit entity solely because it does not receive other federal financial assistance.

In carrying out this strategy to integrate federal programs the Department also has encouraged some community and migrant health centers to take the assignment of NHSC members even though they could have recruited health professionals. It is the Committee's view that this is an inappropriate use of the NHSC. Community and migrant health centers should be strongly encouraged by the Department to recruit health professionals to join their programs. If a center can recruit an individual who wants to serve in its community, the NHSC will benefit by being able to serve another community in need of health professionals.

(3) Cost sharing for public entities

The Committee's bill prohibits the Secretary from discriminating against public entities in determining whether to grant their request for a waiver of the cost-sharing requirements of Sec. 334 of the Public Health Service Act.

Under current law, all entities seeking assignment of NHSC members must agree to reimburse the Secretary for the salary and allow-

ances paid to the NHSC members, plus a proportionate share of any scholarship or loan assistance given to members. The Secretary is authorized to waive this requirement if (1) It is determined that the entity is financially unable to comply or if compliance would unreasonably limit the entity's ability to support the delivery of care by NHSC members; or (2) the entity is located in a health manpower shortage area in which a significant percentage of the residents are elderly, poor, or otherwise unable to pay for services rendered by the entity.

In administering this waiver, the Secretary has taken the position that State and local governmental entities are not eligible for the waiver of the cost-sharing requirements unless they also receive financial assistance under sections 330 [Community Health Centers] or 319 [Migrant Health] of the Public Health Service Act. The basis for the Secretary's position appears to be an assumption that state or local tax levy funds are available to public entities which do not receive such federal grant support. The Committee does not understand this assumption. In many circumstances, such tax funds are not in fact available; so this policy has unnecessarily penalized public entities and, in particular, public general hospitals.

Public health departments and the outpatient clinics and emergency rooms of public general hospitals often function in lieu of family physicians for many Americans living in areas with shortages of health manpower, particularly those persons with little or no health insurance coverage. Despite their critical role in serving the medically indigent, many of these health departments and general hospitals have been forced to reduce staff and cut back on essential primary care services because of shrinking local tax bases and increased competition for reduced municipal or county revenues. These fiscal problems have been further compounded for many public general hospitals by the reduced number of foreign medical graduates available to fill housestaff positions. This reduction was an intended effect of Public Law 94–484, but had the undesirable side effect of reducing medical services for populations relying on public general hospitals.

It is the Committee's view that these public entities, particularly public general hospitals, are providing needed health care services to the medically indigent residents of health manpower shortage areas. Without their services, many of the residents would be without health care. The Committee expects the NHSC to make NHSC members available to these public health facilities. These assignments should be made under the same terms and conditions as apply to assignments to private nonprofit entities.

The Committee's bill would end the current administrative policy which precludes public entities from qualifying for a waiver of the cost-sharing requirements.

(4) Technical assistance to National Health Service Corps sites

The Committee found that the Department's current efforts to provide assistance through consultant contracts and its regional office staff to areas which need health professionals are insufficient. Neither the consulting firms nor the regional offices are in a position to provide the type of assistance needed. The Committee believes that regional office staffs will be strained even beyond their current capac-

ity during the next few years due to the rapid increase in the number of NHSC members and the expected growth in the number of community and migrant health centers.

Due to the recognition in recent years of the unmet need for primary health care, public and private organizations with expertise in the planning, development and operation of primary health care centers have developed throughout the country. The Committee believes it is imperative for the Department to coordinate the activities of the NHSC with these public and private organizations and intends that the Department do so. They can assist the NHSC in the most crucial phase of the development of the primary health care centers to which NHSC members will be assigned.

There are a number of important determinations which must be made before an NHSC member is assigned to an area. What services do the residents of an area have available to them and what services do they need? At what rate would they use these services? Which location for a health center is most likely to be accessible to, and used by, those residents who need services? If mistakes are made during the early planning phase the health center and its NHSC members might not be utilized to the greatest extent, too many members might be assigned to a center, members with the wrong types of health professional training might be assigned, and members might provide services which are not used by the area's residents or not provide services which are needed by the area's residents.

The Committee believes that some state governments, some local governments, and some private nonprofit organizations operating solely within one state currently have the capacity, or can develop the capacity, to provide technical assistance to communities in planning, developing and operating primary health care centers staffed by NHSC members. Because these governments and organizations are more familiar with and are physically closer to the targeted communities and areas, they can improve upon and extend the capabilities of the Department to carry out the goals of the NHSC. The Committee does not view the involvement of these public and private agencies as adding an additional and duplicative layer of bureaucracy, but as cordinating with the Department to perform functions for the Department which the Department would otherwise have to perform through its regional offices.

The Committee's bill would require the Secretary to enter into agreements with state and local governments and with other public and non-profit private entities (operating solely within one state) which have expertise in the planning, development and operation of primary health care centers. The Committee intends for the Department to enter into a sufficient number of agreements to determine whether improvements can be made in the assignment of NHSC members to HMSA's. A sufficient number of agreements would include several state governments, several city or county governments, and several private nonprofit entities.

In recognition of the expertise required to provide the assistance the Committee believes is necessary, the Committee's bill would require agreements only with "qualified entities"—those able to perform the seven functions described in the bill. In addition, a "qualified entity" would have to develop a program for the planning, development, and

62-655 O - 80 - 3

operation of primary health care centers in health manpower shortage areas (within its state, jurisdiction, or part of its state) which reasonably addresses the need for such care in those areas. For those qualified entities which develop such a program and will perform the necessary functions, the Secretary would assign members of the NHSC in accordance with their programs. The primary health care centers assisted by the qualified entities in accordance with their programs would still make application for the assignment of NHSC members and have to meet the same requirements as other NHSC sites.

The committee believes these agreements will encourage state and local governments and other public and nonprofit private organizations to use their financial resources to develop a staff capable of performing the necessary functions. The benefit to them is the assignment of NHSC members to the primary health care centers which they assist.

The functions which qualified entities must be capable of performing are those which the Committee believes are essential to the development of a well planned, productive and efficient primary health care center. It is not necessary that the entities actually operate primary health care centers but that they have expertise in assisting in the operation of a center. So that the entities can best recruit health professionals, the Committee expects the Secretary to make available to the entities the names of scholarship recipients available for service as members of the NHSC. The list would be provided well in advance of the date the scholarship recipients would begin service, so that the entities could make personal contact with them. The entities would attempt to match those individuals with a community and a primary health care center which they have assisted. In retaining health professionals, entities would have to make all reasonable efforts to arrange continuing education and other activities which contribute to retention. Assistance in the development of a clinical practice would include patient referral patterns.

The Committee intends that the Department evaluate the performance of a qualified entity which has an agreement based upon whether it carried out its program for planning, development and operation of primary health care centers; whether it performed the required functions; and whether the performance of the primary health care centers which were assisted by the entity, was adequate.

The Committee also intends that these qualified entities assist NHSC scholarship recipients who choose to exercise the private practice option in establishing their practice.

In those areas where the Secretary does not enter into an agreement with a qualified entity, the Secretary would be required to provide similar technical assistance to public and private non-profit organizations which desire to apply to the NHSC for the assignment of an NHSC member. The Committee intends for the Department to develop criteria, and methodologies for the application of that criteria, so that the applicant organization may determine the need for health professionals in its area, analyze the potential use of those professionals in a defined health service delivery area, determine the extent to which its area has a financial base to support the practice of those health professionals, and to determine the types on in-patient and other health services which those professionals should provide in its area.

(5) Health professions societies' comments

Before an NHSC member is assigned to a community, the Secretary should know the opinions of the local health professions societies as to the need for that member. To assure the availability to the Secretary of this input, the Committee's bill would require the Secretary to give health professions societies 90 days during which they could comment on the assignment of an NHSC member to their area. The bill also requires each HSA to consider the comments of the health professions societies when reviewing the potential assignment of an NHSC member to its area.

(6) Preparation for practice in a health manpower shortage area (HMSA)

The Committee's bill would establish new authority for the Secretary to support projects designed to prepare scholarship recipients to provide services in HMSA's. By identifying young physicians and other health professionals at the beginning of their training, they can be specifically prepared to practice in rural and other shortage areas. This opportunity has not, to date, been utilized by the Department.

Under the provisions of the new section 337, the Department would make grants to and enter into contracts with medical schools, residency training programs, Area Health Education Center programs, and organizations with experience and interest in providing on-going training opportunities for NHSC scholarship recipients. The types of projects which the Committee anticipates would be developed include: (i) providing preceptorships in shortage areas for students during the summer between their first and second year of medical training; (ii) providing a variety of opportunities for elective clerkships during the third and fourth years of undergraduate training; (iii) working with primary care training programs in specific locations in or near shortage areas to provide longer residency training directed toward shortage area practice; and (iv) establishing programs to train final year residents in the management of shortage area practices.

The Committee also expects the Department to conduct appropriate experiments under which medical or other health professional schools would select a limited number of first year students for NHSC scholarships and provide those students with a specific shortage area oriented program throughout their school years. While such a program would be very different from the current method of selecting Corps scholarship recipients, and therefore would have to be tested on a demonstration basis and extensively evaluated, it offers new potential regarding the ability of the scholarship program to provide health professionals for shortage areas.

c. Private practice option

The Committee's bill would remove certain restrictions on the exercise of the private practice option (provided for in section 753 of the Public Health Service Act) in order to encourage more NHSC scholarship recipients to use the option. To assure that NHSC scholarship applicants are aware of the revised private practice option, the Secretary would be required to advise them of the option upon their application. In addition, the Secretary would be required to inform all individuals and public or private nonprofit entities in HMSA's of the increased availability of NHSC scholarship recipients who can ful-

fill their scholarship obligation by exercising the private practice option in their HMSA. The Committee intends for the Secretary to be especially active in advising these individuals and organizations. For instance, the Secretary could advise national organizations, such as the U.S. Chamber of Commerce or the American Academy of Family Practice, which have member organizations or members in HMSA's, of the availability of primary care physicians and other health professionals through their exercise of the private practice option.

The bill also requires the Secretary, upon request, to provide technical assistance to NHSC scholarship recipients who are considering exercising the private practice option, or have chosen it, to assist them in evaluating the establishment of, or in establishing, their clinical practice.

During the Committee's deliberations, questions were raised about the availability of the private practice option to those individuals who received scholarships under Sec. 225 of the Public Health Service Act, as in effect on Sept. 30, 1977—the scholarship program which preceded the current NHSC scholarship program. It is the Committee's view that the private practice option of Sec. 753 is available to these earlier scholarship recipients. The provisions in the Committee's bill simply clarify this point.

The Committee's bill would remove certain restrictions from the exercise of the private practice option. The option could be exercised in any HMSA, not just those with a priority for the assignment of NHSC members; and the Secretary would not be required to determine if the HMSA had a sufficient financial base to sustain the private practice by providing the NHSC scholarship recipient with an income equal to the income of an NHSC member. It is the Committee's view that an NHSC scholarship recipient should be encouraged to enter into private practice in any area which has a shortage of health professionals. Therefore, all HMSA's should be eligible for the exercise of the private practice option. In addition, if a scholarship recipient is willing to assume the financial risk of establishing a private practice in an HMSA, that individual should be permitted to make his or her own determination as to whether there is a sufficient financial base to support a practice. Any individual exercising the private practice option would be required to accept assignment for all Medicare services they render and to participate in the state's Medicaid program.

If an individual breaches his or her agreement to exercise the private practice option for the duration of his or her service obligation, the Secretary could permit that individual to perform the rest of the service obligation as a member of the NHSC. If an individual who received a scholarship under Section 225 of the Public Health Service Act (as in effect on September 30, 1977) entered into the private practice option and failed to begin or complete his or her service obligation in accordance with his or her agreement, he or she would be subject to the penalties set forth in Section 225(f), as in effect on September 30, 1977.

Under current law special grants are available to NHSC members who complete their service obligation and wish to enter into private practice in HMSA's. The Committee's bill would make those

grants available to members after they complete 2 years of their service obligation. If NHSC members with service obligations in excess of 2 years to remain permanently in an HMSA by setting up their private practice, special grants should be available to assist them at that time.

d. NHSC revolving fund

Currently monies paid back to the NHSC under the "cost sharing" provisions of section 334 of the Public Health Service Act are paid into the United States Treasury and are not available for carrying out the NHSC program. It is the Committee's view that these funds should be used for the purposes of the NHSC. Accordingly, an NHSC revolving fund would be established by the Committee's bill. Monies deposited in the fund would be available to the Secretary only to carry out the NHSC program.

The Committee expects that, as these monies build up, the Appropriations Committee would use them to offset appropriations for the NHSC. The Committee believes it would appropriate for only those monies actually in the fund, not those monies projected to be received by the fund during the succeeding fiscal year, to be used to offset appropriations for a succeeding fiscal year.

e. Savings which accrue due to committee amendments

The Committee believes that changes made by the Committee's bill will reduce the cost of operating the NHSC. By permitting the Secretary to assign NHSC members as employees of public and private nonprofit organizations, all or part of the income of those members will be paid by those organizations. By removing some of the restrictions on the exercise of the private practice option, more NHSC scholarship recipients will use that option in lieu of becoming members of the NHSC. And by establishing a NHSC revolving fund, monies paid back will be reused in the program.

The Committee determined that it is impossible at this time to realistically estimate the potential savings which will accrue from these provisions. Therefore, the Committee's authorization levels do not reflect these potential savings. To the extent that savings do accrue from the implementation of these provisions, appropriations in future years can be reduced below the level of authorizations provided in the bill without affecting the strength of the Corps as envisioned by the Committee.

f. Scholarship program

The Committee's bill would specifiy that the Secretary may award scholarships to clinical psychologists to the extent they are needed by the NHSC.

The Department has determined that severe shortages of foot care practitioners exist in the country and will continue throughout the 1980's. The Committee acknowledges the Department's recent efforts to counter these adverse trends. For the 1979–80 academic year, the Department granted 106 NHSC scholarships to podiatric medical students. These awards, in addition to those the Department should grant in future years, are essential to meet the foot care needs of the residents of HMSA's.

The Committee's bill would require the Secretary, in awarding NHSC scholarships, to give special consideration to those individuals who intend to be primary care physicians in HMSA's, who have resided or been employed in such areas, or who meet other qualifications the Secretary prescribes to assist in determining if an individual will become a primary care physician in an HMSA. If an individual, for instance, has resided or been employed in an HMSA for a reasonable period of time, that individual is more likely to return to that area to provide health services. These criteria are currently being used to evaluate scholarship applications. The Committee expects the Department to use these criteria and any others which indicate that an individual is interested in providing health services in an HMSA.

The Committee proposal clarifies policy with respect to NHSC scholarship recipients who subsequently receive a National Research Service Award. Present regulations of the Secretary provide that only scholarship recipients who receive individual NRSA awards may receive credit for NHSC service. The Committee proposal indicates that recipients of institutional NRSC awards should also be given such credit. The Committee anticipates that this inclusion of institutional-based awards will not be abused by individuals and institutons to avoid service in shortage areas by professionals who do not truly intend to pursue careers in biomedical research. Individuals who receive credit for NHSC service by accepting NRSA awards do, of course, assume new responsibilities under the "payback" provisions of subsection (c) of section 472.

g. Authorizations

The Department estimates that the NHSC will have a total field strength of 1950 on September 30, 1980. This estimate includes increase in the fiscal year 1980 personnel ceiling of approximately 100 persons. If all funds authorized by the Committee's bill for the NHSC are appropriated, and the personnel ceiling is raised accordingly, the NHSC would have, by the Department's estimates, a total field strength of 2958, 3881, and 5073 respectively at the end of fiscal years 1981, 1982, and 1983.

The Committee's authorization of $94 million for fiscal year 1981 is the same as the President's budget request. The authorizations of $145 million and $205 million, respectively, for fiscal years 1982 and 1983 are based upon the Department's future projections of the President's fiscal year 1981 budget.

The Committee's authorization of $92 million, $101 million, and $109 million, respectively, for fiscal years 1981, 1982 and 1983 would permit the following scholarship awards if appropriations are consistent. These figures were estimated by the Department:

	Total awards	New	Continuations
Fiscal year:			
1981	6,572	1,902	4,670
1982	6,701	2,587	4,114
1983	6,701	1,735	4,966

The Committee's fiscal year 1981 authorization is the same as the President's budget request.

Title II—Health Professions Programs Under Title VII

Part A—Construction Assistance

1. Legislative background

In 1963, Congress considered legislation which would provide direct Federal financial assistance for health professions education. The Report of the House Committee on Interstate and Foreign Commerce on H.R. 12, the Health Professions Educational Assistance Act of 1963, observed that such support was necessary in order to increase the supply of professional health personnel. According to the Committee, Federal grants had stimulated very substantial programs for the construction of health research facilities, hospitals, and other health facilities. If Federal funds were not also available for medical education and the training of other health professions, investments in medical research and other health facilities would be jeopardized.

For these reasons, Congress passed the Health Professions Educational Assistance Act of 1963, thereby authorizing matching grants for the construction, expansion, remodeling and repair of health professions schools (schools of medicine, dentistry, osteopathy, pharmacy, optometry, podiatry, nursing, and public health), and providing loans for students in three of the health professions (medicine, osteopathy, and dentistry). The House Committee on Interstate and Foreign Commerce and the Senate Committee on Labor and Public Welfare agreed in their reports that the amounts of individual construction grants should vary with the extent of expansion of enrollment undertaken by the health professions schools. For example, grants for new schools or for "major" expansions of existing schools could be awarded up to 66⅔ percent of the costs of construction; whereas for projects which could not be considered "major", grants could not exceed 50 percent of the costs of construction.

In the case of projects to expand the capacity of an existing school, applicant institutions were required to increase their first-year enrollments by at least 5 percent over the highest first-year enrollment in the preceding five years, or by five students, whichever was greater, and to maintain this increased enrollment for at least 10 years after completion of construction.

This construction authority has been extended and amended several times since 1963, as Congress has considered legislation which would extend Title VII health manpower training programs. In 1971, with the enactment of the Comprehensive Health Manpower Training Act of 1971, Public Law 92–157, the maximum Federal share of the costs of construction for new schools or major expansion of existing schools was raised from 66⅔ percent to 80 percent. The 80 percent maximum was applied as well to projects for major remodeling or renovation of an existing facility where this project was required to meet an increase in student enrollment. For other projects, the maximum was raised from 50 percent to 70 percent, except where unusual circumstances made a larger percentage (not to exceed 80 percent) necessary in order to accomplish the purposes of this program.

In addition, Public Law 92–157 expanded the definition of construction to include the acquisition of existing buildings (but not the land on which they stand) and the costs of interim facilites to provide space

on a short-term basis while facilities of a more permanent nature were being planned and constructed.

This enactment also initiated a program of construction loan guarantees and interest subsidies for private, nonprofit health professions schools. Such guarantees could apply to amounts no greater, except under special circumstances, than 90 percent of construction costs. Up to 90 percent of losses on loan principal and interest could be covered. Interest subsidies could reduce, by no more than 3 percent per year, the net interest rate otherwise payable on loans.

Among additional provisions contained in the 1971 Amendments to the Title VII construction assistance authority, one other should be noted. Public Law 92–157 broadened the eligibility for construction aid to include outpatient facilities affiliated with a school of medicine, osteopathy, or dentistry.

As Congress began to consider revision and extension of health manpower training programs in 1974, the need to increase the aggregate supply of health personnel no longer commanded the concern it had in prior years. Rather, problems associated with the geographic and specialty maldistribution of health professions were perceived by the Congress to be the issues requiring legislative response. Amendments to the construction assistance authority of Title VII reflected these concerns.

As finally enacted, the Health Professions Educational Assistance Act of 1976, Public Law 94–484, added a new authority for grants to public and non-profit private entities to assist in the construction of ambulatory, primary care teaching facilities for the training of physicians and dentists. Under this new construction assistance authority, ambulatory and primary care teaching facilities were defined as areas intended for the training of students in the diagnosis and treatment of ambulatory patients, and primarily used for training in the specialties of family practice, general pediatrics, general internal medicine, general dentistry, and pedodontics. The amended law specified that, of the total sums appropriated for construction grants, 50 percent would be required to be obligated for grants for ambulatory primary care teaching facilities and 50 percent for grants under the existing construction grant authority.

Another amendment required the Secretary, in awarding grants to assist in the costs of the construction of teaching facilities for the training of physicians (schools of medicine and osteopathy) to give special consideration to projects in States which have no such training facilities.

In addition, Public Law 94–484 included a provision which amended, for fiscal year 1977 only, the construction grant authority to allow clinical facilities affiliated with a school of veterinary medicine, optometry, podiatry, or pharmacy (VOPP) to apply directly for a grant for the construction of a facility having as its purpose the establishment or expansion of a regional health professions program. Also, the existing authority was amended to require the Secretary to give special consideration to applications for facilities to establish or expand VOPP regional health professions programs.

The following tables detail funds awarded for the construction grant program since 1965.

TABLE 13.—AMOUNT OF CONSTRUCTION GRANT FUNDS AWARDED TO SCHOOLS FOR HEALTH PROFESSIONS TRAINING, BY OCCUPATION, FISCAL YEARS 1965–79

[In thousands of dollars]

Fiscal year	Total	Occupation							
		Medicine [1]	Osteopathic medicine	Dentistry	Optometry	Pharmacy	Podiatric medicine	Veterinary medicine [2]	Public health
Total	[3] 1,255,064	812,802	28,453	246,986	17,506	31,371	10,417	77,390	30,139
1965	[3] 81,173	53,827	0	19,180	1,156	40	0	----------	6,970
1966	[3] 61,735	41,854	0	14,997	1,182	2,975	0	0	727
1967	137,545	90,957	1,925	35,539	0	4,863	0	0	4,260
1968	114,795	79,359	6,538	23,416	2,759	1,386	0	1,153	184
1969	130,291	85,799	0	31,380	0	536	0	5,492	7,084
1970	133,559	96,715	488	29,633	0	6,141	0	582	0
1971	125,319	81,099	0	25,726	1,989	3,083	4,249	9,173	0
1972	10,465	9,198	0	1,268	0	0	0	0	0
1973	50,385	28,167	0	10,144	1,711	252	0	10,111	0
1974	98,792	66,410	8,456	12,912	0	3,359	979	0	6,676
1975	35,631	17,770	0	5,549	0	1,725	2,070	8,517	0
1976	157,799	111,295	4,250	18,899	4,977	6,540	0	11,212	625
Transition quarter	17,309	3,486	2,600	4,490	0	0	3,119	0	3,614
1977	89,240	35,841	4,196	13,854	3,732	469	0	31,149	0
1978	6,736	6,736	0	0	0	0	0	0	0
1979	4,289	4,289	0	0	0	0	0	0	0

[1] Including grants to university and affiliated hospitals.
[3] Included in program beginning in fiscal year 1966.
[3] Excluding construction grants for nurse training.

Note: Detail may not add to total due to rounding.

Source: (1) Trends in BHM Program Statistics, Grants, Awards, Loans fiscal year 1957–77, DHEW HRA, BHM. (2) 1978 and 1979 data provided by the Bureau of Health Facilities, DHHS, HRA.

TABLE 14.—NUMBER OF SCHOOLS[1] AWARDED CONSTRUCTION GRANTS FOR HEALTH PROFESSIONS TRAINING, BY OCCUPATION, FISACL YEARS 1965–79

Fiscal year	Total	Occupation							
		Medicine[2]	Osteopathic medicine	Dentistry	Optometry	Pharmacy	Podiatric medicine	Veterinary medicine[3]	Public health
Total[4]	[5]206	98	7	43	8	26	4	10	10
1965	[5]28	14	0	8	2	1	0		3
1966	[5]22	11	0	5	1	4	0	0	1
1967	39	21	1	9	0	6	0	0	2
1968	28	16	1	5	2	2	0	1	1
1969	18	10	0	3	0	1	0	3	1
1970	25	11	1	7	0	5	0	1	0
1971	24	14	0	5	1	1	1	2	0
1972	6	4	0	2	0	0	0	0	0
1973	11	6	0	2	1	1	0	1	0
1974	20	12	2	2	0	2	1	0	1
1975	14	5	0	4	0	2	1	2	0
1976	39	24	1	5	1	4	0	3	1
Transition quarter	7	2	2	1	0	0	1	0	1
1977	21	10	1	3	1	1	0	5	0
1978	3	3	0	0	0	0	0	0	0
1979	1	1	0	0	0	0	0	0	0

[1] Grants made jointly to 2 or more schools are counted under each school.
[2] Including grants to university and affiliated hospitals.
[3] Included in program beginning in 1966.
[4] Total number of schools receiving grants may be less than sum of numbers by year because some schools received grants in more than 1 yr.
[5] Excluding construction grants for nurse training.

Sources: (1) Trends in BHM Program Statistics Grants, Awards, Loans Fiscal Year 1957–77, DHEW, HRA, BHM. (2) 1978 and 1979 data provided by Bureau of Health Facilities, DHHS, HRA.

2. Proposed legislation

As reported from the Committee on Interstate and Foreign Commerce, H.R. 7203 would make several changes in the programs of construction assistance to the health progressions institutions. Consistent with the Committee's views that enrollment increases stimulated by past health manpower legislation have produced levels at which continued growth in many professional areas is no longer necessary, the Committee proposal would repeal the enrollment increase requirement in the construction grant program. In addition, previous construction grant recipients would be relieved of any existing requirement for maintenance of enrollment which results solely from the receipt of such a grant.

The Committee is aware of the need for existing accredited institutions currently offering the first two years of undergraduate medical education to receive construction grant assistance to become four year schools of medicine. Accordingly, the Committee bill would authorize $15 million for construction grant assistance for that purpose.

The Committee proposal would provide no other construction grant authority or new interest subsidy authority for schools of the health professions, and would authorize loan guarantees only for projects for remodeling, renovation, or alteration—rather than for new construction—of health professions teaching facilities for the next three fiscal years.

PART B—STUDENT ASSISTANCE

1. Background

With the enactment of Public Law 88–189, in 1963,[1] the Federal Government began to provide direct financial assistance to schools and students of the health professions. Since that time, Federal health professions student assistance programs have been used to further perceived national goals for health manpower.[2] During this period, the traditional objective of student assistance programs of meeting specific student financial needs, especially of students from disadvantaged backgrounds, has been maintained.

The 1963 Health Professions Educational Assistance Act marked the first time the Federal Government accepted a significant role in underwriting the development of an adequate supply of health manpower for this country. Prior to that time, the Government's role in health manpower programs had been limited to indirect support for public health programs and biomedical research. The purpose of the 1963 legislation was summed up by the Committee's report which stated that the Act:

> . . . proposed a three-year program designed to alleviate critical shortages of professional health personnel which already have begun to affect the level of quality of health care in this Nation. Those shortages threaten to become worse

[1] Public Law 88–129, Health Professions Educational Assistance Act of 1963.
[2] Michael Koleda and John Craig. A New Era in Medical School Finance, 1976–80. National Planning Association—Looking Ahead and Projection Highlights, vol. 11, September 1976, p. 1.

during the next decade unless immediate steps are taken to increase the supply of professional health personnel.[3]

Committee reports and hearings from the 1960's indicate that the authorization of Federal loan and scholarship programs was part of the overall effort to cure a critical nationwide shortage of health professionals.[4] A substantial body of testimony on the 1963 legislation stressed the need for some measure of financial assistance to medical and dental students if the necessary increase in qualified applicants to health professions schools were to be realized.[5]

In response to the above concerns, the 1963 legislation provided authority for health professions loans for financially needy students in medicine, oesteopathy, and dentistry to encourage applicants and insure that qualified low-income persons would not be excluded from attending such schools. The loan program was extended by Public Law 88–654 in 1964 [6] to add optometry students, by Public Law 89–290 in 1965 [7] to include pharmacy and podiatry students, and by Public Law 89–709 in 1966 [8] to cover veterinary medicine students.

Public Law 89–290 also authorized a loan forgiveness program for students of medicine, dentistry, optometry, and osteopathy receiving student loans who agreed to practice in health manpower shortage areas as designated by the Department of Health, Education, and Welfare (HEW). This loan forgiveness program was later expanded by Public Law 92–157 in 1971 [9] to include students of veterinary medicine, pharmacy, and podiatry. That legislation also aided health professions students who were in exceptionally needy circumstances and from low-income or disadvantaged families. Full forgiveness for any educational loan was extended to these students if they had not resumed their studies or could not be expected to return to school within two years after they ended their studies.

The 1965 health manpower Act authorized a scholarship program for low-income students of medicine, osteopathy, dentistry, optometry, podiatry, and pharmacy who were unable to pursue their studies without such assistance. Veterinary medicine students were included in the scholarship program by Public Law 89–709 in 1966.

Although the original intent of health manpower legislation centered on increasing the supply of health personnel, Congress also recognized other objectives when authorizing student assistance programs. Congress expected these programs not only to expand the ranks of health professions personnel, but also to improve the quality of health professions students entering schools by increasing the number of applicants for admission and to increase the proportions of health professions students from low-income families.[10] For example, the Com-

---

[3] U.S. House of Representatives. Committee on Interstate and Foreign Commerce. Health Professions Educational Assistance; Report to Accompany H.R. 12. Washington, U.S. Government Printing Office, 1963 (88th Congress, 1st session, H. Rept. No. 109), p. 3.

[4] U.S. House of Representatives. Committee on Interstate and Foreign Commerce, Subcommittee on Public Health and the Environment. Health Manpower and Nurse Training, 1974. Hearings. 93d Congress, 2d session. May 20, 21, 22, 23, 28, 29 and June 27, 1974. Washington, U.S. Government Printing Office, 1974; p. 1209.

[5] U.S. House of Representatives. Committee on Interstate and Foreign Commerce. Health Professions Educational Assistance, 1963; p. 15.

[6] Public Law 88–654, Amendments to the Public Health Service Act.

[7] Public Law 89–290. Hea'th Professions Educational Assistance Amendments of 1965.

[8] Public Law 89–709, Veterinary Medical Education Act of 1966.

[9] Public Law 92–157, Comprehensive Health Manpower Training Act of 1971.

[10] U.S. House of Representatives. Committee on Interstate and Foreign Commerce. Subcommittee on Public Health and the Environment. Health Manpower and Nurse Training, 1974: pp. 1209–1210.

mittee's report on Public Law 89–290 in 1965 commented that the students who would benefit most from the new scholarship program were those who, because of limited financial resources, were not likely to attempt to enter certain health professions due to the high costs of tuition and other educational expenses.[11] Later, the Committee, in its 1971 report, stated:

> As new schools come into being and existing schools are expanded to increase enrollment to relieve manpower shortages, funds must be available to assist needy students. In recent years there has been increasing concern over rising costs of professional education. A substantial proportion of health professions students go into debt before graduation. The health professions student loan program has made a major contribution in assisting students to undertake and complete their professional evaluation.[12]

With the enactment of P.L. 92–157 in 1971, congressional focus on health manpower policy, including student assistance programs, began to shift. As the seventies progressed, the need to increase the aggregate supply of health professionals no longer was perceived to be as critical as in previous years. For example, enrollment increased in medical schools from 32,001 in the 1963-64 academic year to 50,886 in 1973-74. During that same time, graduates of medical schools increased from 7,336 to 11,613.[13]

Underlying the debate in 1975 and 1976 on the Health Professions Education Assistance Act of 1976, Public Law 94–484, was concern that medical schools and students should share the responsibility for meeting national health manpower goals, especially since the Federal Government was underwriting a substantial portion of the costs of medical education.[14] Schools were being encouraged to place more emphasis on primary care training and the selection of students who might choose to practice in underserved areas. These concerns led to the enactment of certain programs in Public Law 94–484, that were designed, in part, to bring about changes in the geographic and specialty maldistribution patterns of health professionals.

In that context, student assistance programs were targeted for the truly disadvantaged. Health professions scholarships were also phased out—only scholarships for first-year students of exceptional financial need remained. The legislation continued the health professions student loan and loan repayment programs on a more targeted basis, limiting loans for medical and osteopathic students to students of exceptional need. A new federally insured student loan program, known as the Health Education Assistance Loan program (HEAL), was also authorized to insure that needed funds were available for health professions students.

---

[11] U.S. House of Representatives. Committee on Interstate and Foreign Commerce. Health Professions Educational Assistance Amendments of 1965 ; A Report to Accompany H.R. 3141. Washington, U.S. Government Printing Office, 1965 (89th Congress, 1st session. H. Rept. No. 781) : p. 14.

[12] U.S. House of Representatives. Committee on Interstate and Foreign Commerce. Comprehensive Health Manpower Training Act of 1971 ; A Report to Accompany H.R. 8629. Washington, U.S. Government Printing Office, 1971 (92d Congress, 1st session. H. Rept. No. 92–258) : p. 36.

[13] Undergraduate Medical Education. Journal of the American Medical Association, vol. 240, December 22/29, 1979 ; p. 2822.

[14] Koleda and Craig, op. cit. p. 1.

2. Current student assistance programs

The health professions student assistance programs authorized under Title VII of the Public Health Service Act are administered by the Bureau of Health Manpower of the Department of Health and Human Services (HHS).

Health professions students are also eligible for other Federal financial student assistance programs, particularly those administered by the Department of Education, to help finance their education. These programs include the National Direct Student Loan Program, the federally insured or State Guaranteed Student Loan Program, and the College Work Study Program. Additional Federal programs include the Armed Forces Health Professions Scholarship Programs, as well as those associated with the Veterans Administration.

The following sections describe the Title VII student assistance programs:

a. Health professions student loans (HPSL)[15]

Under this program, Federal loans are available to full-time students of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, and pharmacy. However, medical and osteopathic students who graduate after June 30, 1979 must have "exceptional financial need" to qualify for such funds. Originally, interim final regulations for this program stipulated that the loans would only be open to medical and osteopathic students who had no other financial resources available to them. However, recent regulations broadened the definition of exceptional financial need under the program. Medical and osteopathic students will now meet that requirement if they have resources equalling less than $5,000 or half the cost of attending school, whichever is less.

The maximum amount a student may borrow under this program is the cost of tuition plus $2,500. The interest rate is seven percent. Participating schools award loans directly to students.

In the past, the Secretary of HHS could forgive any loan under this authority if the borrower agreed to serve at least two years in a designated health manpower shortage area, either in private practice or as a member of the NHSC. However, HHS has announced in the Federal Register its decision to phase out this part of the loan forgiveness program.[16] The Secretary is also authorized to forgive all or any part of loans made to students of medicine, osteopathy, dentistry, veterinary medicine, optometry, pharmacy, or podiatry if it is determined that a student has (1) failed to complete his studies leading to his first professional degree; (2) is an exceptionally needy circumstance; (3) is from a low-income, or disadvantaged family (as defined by regulations); and (4) has not resumed, or cannot be reasonably expected to resume, his professional studies wtihin two years after termination.

b. Health education assistance loans program (HEAL) [17]

Under this program, students of medicine, osteopathy, dentistry, podiatry, optometry, public health, and veterinary medicine may borrow

[15] Public Health Service Act, sec. 740–744.
[16] Health Professions Loan Repayment Program, Federal Register, v. 44, July 30, 1979, p. 44624.
[17] Public Health Service Act, secs. 727–739.

from non-Federal lenders up to $10,000 per year (up to an aggregate of $50,000) at an interest rate not to exceed 12 percent (plus an insurance premium not to exceed two percent). Pharmacy students who are eligible only after completion of three years of training, may borrow up to $7,500 a year and a total of $37,500. In the case of students in schools of medicine, osteopathy, and dentistry, the Secretary of HHS may increase the total of a HEAL loan to $15,000 per year (up to an aggregate of $60,000) if he determines that the costs of education at such schools require such an increase. Defaults on loans are insured up to 100 percent of the principal and interest by HHS. A HEAL borrower cannot receive a loan under this program during the same year in which he or she received a Guaranteed Student Loan as administered by the Office of Education. Loans may be used for tuition and other reasonable educational expenses such as fees, books, and lab expenses. Interest may be paid while the borrower is in school or it may accrue and compound.

A HEAL loan may be repaid over a 10 to 15 year period starting 9 to 12 months after completion of training. However, payments of principal are not required during periods of up to three years of internship and residency training or during service in the Armed Forces. NHSC, Peace Corps, or Volunteers in Service to America (VISTA). A loan must be repaid in full within 23 years after it is made. At HHS' discretion, borrowers may enter into agreements with the Department for the repayment of loans, plus interest, at a rate not to exceed $10,000 a year for each year of service in the NHSC or in private practice in a health manpower shortage area. Minimum service is two years.

Eligible lenders include a health professions or public health school, a State agency, a financial or credit institution, or a pension fund. For students to take part in the program, their school must be receiving or be eligible to receive a capitation grant as authorized under Public Law 94–484. This requirement does not apply to medical students whose school failed to qualify for capitation solely because it did not comply with the requirement for a third-year enrollment increase in the 1978–79 school year. No more than 50 percent of the students in each class of a medical, osteopathic, or dental school can be borrowers under this program.

c. Scholarships for first-year students of exceptional financial need (EFN)[18]

Under this program, scholarships are available to full-time students of medicine, osteopathy, dentistry, optometry, podiatry, pharmacy, and veterinary medicine who are in exceptional financial need and who are in their first year of study. Students classified as "exceptionally financially needy" are those who have practically no financial resources. The amount of the scholarship is the same as an NHSC scholarship, in that it includes tuition and all other reasonable education expenses, including fees, books, and laboratory expenses; plus a stipend of $400 per month for 12 months. Participating schools awards scholarships. Priority is given to schools of medicine, osteopathy, and dentistry.

[18] Public Health Service Act, sec. 758.

d. Lister Hill scholarships [19]

If funded, ten scholarships would be available each year for medical students who agree to enter family practice in a health manpower shortage area. However, no awards have been made under this program due to lack of funds.

(3) Need

Congressional support for Federal students assistance programs for health professions students has changed since the inception of the Health Professions Student Loan program in 1963. The most recent health manpower legislation, Public Law 94–484 required students to share, to a greater extent, the responsibility for the costs of their education.

During this period, the costs of health professions education has risen. For example, Table 15 illustrates tuition increases charged students by medical schools. Particularly striking is the increase in the average tuition at private medical schools. Between academic years 1975–76 and 1978–79, tuition increased 65 percent. For non-residents at public medical schools, average tuition increased by 45 percent during this period. For residents at public medical schools, this increase amounted to 43 percent.

TABLE 15.—TUITION FOR THE ENTERING CLASS: PUBLIC AND PRIVATE MEDICAL SCHOOLS, 1960–61 TO 1978–79

	Range	Median	Average
Public medical schools (State residents):			
1978–79	$180 to 4,000	$1,370	$1,634
1977–78	$267 to 4,000	1,319	1,445
1976–77	$267 to 3,000	1,200	1,274
1975–76	$300 to 2,300	(1)	1,139
1970–71	$200 to 1,000	683	(1)
1965–66	$175 to $900	600	(1)
1060–61	(1)	498	(1)
Private medical schools:			
1978–79	$2,400 to $12,500	$5,685	$6,114
1977–78	$1,850 to $12,500	5,000	5,334
1976–77	$1,850 to $7,000	4,500	4,619
1975–76	$1,850 to $5,000	(1)	3,767
1970–71	$1,069 to $2,620	2,000	(1
1965–66	$861 to $2,000	1,440	(1)
1960–61	(1)	1,050	(1)

[1] Not available.

Source: Unpublished data provided by the Association of American Medical Colleges.

With tuitions at the above levels, a loan of $8,000 per year for four years to cover tuition and living expenses would probably not be unusual. However, under one Federal student assistance program, Health Education Assistance Loans (HEAL), a student borrowing that amount would, under current interest rates, have to repay a total of $148,000 or $822 per month for 15 years starting three years after graduation to liquidate the debt.

As might be expected in view of the rising costs of health professions education, the debt level of health professions students increased in recent years. In 1978, the Association of American Medical Colleges issued a preliminary report, Studies of Medical Student Financing, 1977–78, which included survey results of how medical stu-

[19] Public Health Service Act, sec. 759.

dents financed their education. The report indicated that the proportion of medical students with debts increased from 44 percent in 1968, to 67 percent in 1975, to 73 percent in 1978. Debts were incurred by 43,200 medical students in 1978. Between 1968 and 1978, the average amount of debt rose from $3,050 to $10,450, an increase of almost 250 percent.[20]

Additional AAMC data reveal that in 1978 and 1979, 76 percent of graduating medical school seniors were in debt each year. Those figures represented increases from 1971 and 1975 when 72 percent and 71 percent, respectively, of graduating medical school seniors were in debt. Average indebtedness for graduating medical students increased from $5,500 in 1971, to $9,000 in 1975, to $13,800 in 1978, and to $15,800 in 1979.[21]

As the costs of health professions education continue to rise, and as students are required to assume a larger share of the costs of their education, their ability to finance education may determine who will consider a career in the health professions in the future. Although the relative representation of financially disadvantaged students in medical schools has increased over the years, the great majority of students continue to come from families with higher incomes. The median parental income of students in medical schools for 1977–78 was $25,000.[22] As Table 16, below indicates, there has been a shift in occupational categories of parents of medical schools students to higher income professions.

TABLE 16.—FATHER'S OCCUPATION OF MEDICAL SCHOOL APPLICANTS AND ACCEPTEES 1973–74 AND 1977–78

Father's occupation	1973–74		1977–78	
	Applied	Accepted	Applied	Accepted
Physician	12.0	13.4	12.6	14.6
Other health profession	4.2	4.4	4.0	4.3
Other profession	25.0	27.6	24.1	25.7
Owner, manager, administrator	20.1	18.9	25.3	25.3
Subtotal	61.3	64.3	66.0	69.9
Clerical or sales	7.6	7.5	5.1	4.7
Craftsman, skilled worker	11.5	9.9	9.6	8.0
Unskilled worker	5.2	4.8	4.5	4.1
Farmer, farmworker	3.1	2.9	2.5	2.4
Subtotal	27.4	25.1	21.7	19.2
Other	11.2	10.5	12.2	11.0
Total percent [1]	99.9	99.9	99.9	100.1
Number responding	34,523	13,019	38,946	15,451

[1] Differ from 100 due to rounding.

Source: AAMC, Medical Education: Institutions Characteristics and Programs (Washington, AAMC), August 1979, p. 14.

There are also indications that the rate of increase in minority student enrollment appears to be leveling off. The number of underrepresented minority (Black American, Mexican American, American Indian, Mainland Puerto Rican) students had risen to 1,433 in 1978–79.

[20] Gordon, Travis L. Studies on Medical Student Financing, 1977–78 (Preliminary Report), Washington, AAMC (Oct. 1978) ; p. 24.
[21] Data provided by the AMMC, May 1980.
[22] AAMC, Medical Education: Institutions, Characteristics and Programs (Washington, AAMC), August 1979 ; p. 14.

The 1978–79 figure represents a slight decrease from the peak of 1,473 in 1974–75.[23] Since 1973, the pool of minority applicants has levelled off to approximately 3,000 per year.[24]

4. Proposed Legislation

In response to the continuing need for financial assistance to health professions students, the Committee proposals extends, revises and expands the three principal existing student assistance programs: The Health Professions Student Loan (HPSL) program; the Exceptional Financial Need (EFN) Scholarship program; and the Health Education Assistance Loan (HEAL) program. The extension of these programs is fashioned in a manner to meet the needs of those students with exceptional financial requirements in the first years of training, as well as those students requiring last dollar support. The program revisions are designed to allow the most effective use of limited funds.

In addition to these programs, health professions students continue to be eligible for National Health Service Corps scholarships, Armed Forces scholarships, and Guaranteed Student Loans, among others.

(*a*) *Health professions student loan program*

The Committee has reviewed the operation of the HPSL program over the past four years and concludes that it is an effective means of providing assistance to health professions students. In particular, the Committee believes that the central feature of the program, school-based revolving loan funds, insures sensitivity to student needs and allows limited funds to be packaged by the institution with other school-based sources of aid, to meet the varying needs of students. For this reason, the Committee does not accept the recommendation of the Administration that this program be phased-out.

The Committee proposal extends the HPSL program through fiscal year 1983 with authorizations of $20 million, $22.5 million and $25 million for fiscal years 1981, 1982, and 1983, respectively. The Committee understands that approximately $16 million, $18 million, and $20 million will also be available from loan repayments for new loans in these same fiscal years.

As a final point, the Committee notes it is impressed that HPSL funds are now being directed to students who actually need them. Reports to the Committee, in 1974, by the GAO, indicated that the program was not well targeted at that time and that funds were being provided to students independent of actual need. The Committee received no such reports this year. The Department and school financial aid officers are to be commended for the improved administration of the program, consistent with the Committee's 1976 directive that these funds be provided to students with the greatest financial need. This focus is an important feature of a loan program that is as highly subsidized as the HPSL program.

5. Exceptional Financial Need Scholarship Program

In 1976, the Committee was concerned by reports that funds from the then health professions scholarship program were not directed

[23] Ibid, p. 3.
[24] Ibid.

to students with the greatest financial need. Consistent with this concern, the Committee converted that program into the current Exceptional Financial Need (EFN) program by specifying that funds should go only to first year students with the greatest financial need. First year students were selected because studies indicate that students from low income backgrounds may be reluctant to enter schools of the health professions if large loans are required at the very beginning of training. Loans may be more appropriate in subsequent years once a student is confident he or she will actually graduate and become a practicing health professional.

Since the institution of the EFN program, scholarship funds have been targeted to students with the least financial resources. In the current year, scholarships are only available for students with no family resources. The Committee is again impressed with the performance of the Department and school financial aid offices in targeting this program to truly disadvantaged students. However, the number of eligible students has greatly exceeded the available number of awards as shown in the following table.

TABLE 17.—SCHOLARSHIP PROGRAM FOR FIRST-YEAR STUDENTS OF EXCEPTIONAL FINANCIAL NEED ACADEMIC YEARS 1978–79, 1979–80

Discipline	Number of schools	Estimated number of eligibles	Amount requested	Number of scholarship awards	Amount awarded	Percentage of students assisted
Academic year 1978–79:						
Medicine	119	1,565	$14,668,534	264	$2,582,857	17
Osteopathy	13	176	1,841,259	28	318,852	16
Dentistry	57	505	5,363,489	127	1,429,935	25
Optometry	10	107	967,210	10	95,667	9
Pharmacy	52	822	5,519,361	52	358,334	6
Podiatry	5	161	1,799,158	5	57,127	3
Veterinary medicine	20	196	1,591,079	20	155,737	10
Total	276	3,532	31,750,090	506	4,998,509	14
Academic year 1979–80:						
Medicine	121	736	7,846,545	376	3,992,792	51
Osteopathy	14	78	912,806	40	481,763	51
Dentistry	56	235	2,885,597	149	1,853,731	63
Optometry	10	50	535,110	10	103,899	20
Pharmacy	46	252	1,833,325	46	337,660	18
Podiatry	5	34	426,942	5	61,382	15
Veterinary medicine	18	66	599,023	18	166,287	27
Total	270	1,451	15,089,348	644	6,997,514	44

Source: HHS, HRA, BHM.

The Committee proposal makes three changes in the EFN program:

(i) In order to help reduce the indebtedness of new professionals from low income backgrounds, the Committee proposal extends the authority to award CFN scholarship assistance to both first- and second-year students in health professions institutions. The Committee expects that sufficient funds will be appropriated to effectively implement this program change. The Committee intends, however, that priority for EFN scholarships be given to first year students from families with the least resources. Only where more than sufficient funds are available to provide support for all of the needy first year students, does the Committee expect awards to be made to students enrolled in the second year of training. The Committee fully anticipates the availability of appropriations to extend this program to second year

students. However, should such funds not be forthcoming, the Committee would expect the Department to continue to place emphasis on the provision of aid to first year students as the Committee recognizes that other forms of scholarship and loan assistance are available to such students after their first year.

(ii) In order to provide financial support for larger numbers of disadvantaged students, the Committee proposal increases authorizations for this program to $30 million, $40 million, and $50 million for the fiscal years 1981, 1982, and 1983, respectively. It is projected that these additional funds will permit the support of all students with less than $5,000 in resources for the first year of training, with some additional funds available for second year students with no resources.

(iii) Finally, the Committee proposal deletes the requirement that EFN funds be provided to students at all schools of the health professions. Under the new provision, it is expected that the Department will be better able to target funds to those schools with large numbers of students with exceptional financial need. This modification should also simplify the administration of the program.

b. Health education assistance loan program

The HEAL program was established by the Committee in 1976. This program is designed to assure the availability of sufficient funds to those health profession students who may need additional financial assistance.

The Committee views the HEAL loan guarantee program as a supplement to the Guaranteed Student Loan (GSL) program. Under the GSL program, guaranteed loans with subsidized interest rates are available to all students to a maximum amount of $15,000. The maximum for loans under the HEAL program is much larger, $60,000. The Committee's view of the HEAL program as last dollar support is supported by the fact that since HEAL loans became available in 1978, only 1821 loans, totaling approximately $14 million, have been guaranteed under the program.

In order to improve the HEAL program, the Committee proposal makes a number of changes, each of which is designed to assure that HEAL loans are available to all students and that the repayment schedule for participating health professionals is convenient. The following changes are proposed in the Committee reported bill:

(i) The limit for loans for a single year is increased to $20,000, and the total amount to $80,000, for students in medical, osteopathic and dental schools.

(ii) The prohibition on a student's receiving a GSL loan and an HEAL loan in the same year is deleted. Thus, a student could supplement funds received under the GSL program with a HEAL loan if his or her remaining eligibility under GSL was insufficient to meet educational costs for a single year.

(iii) A provision that interest need not be paid during the period of undergraduate and residency training is added to the statute. The existing authority requires students and residents to make what may be sizable interest payments during periods in which they have little discretionary income. The deferral of payments during these periods will shift the burden to those years in health professionals' careers when their practices are established.

(iv) The allowed period for the deferral of loan payments during residency training is extended from three to four years. This provision accommodates recent changes in postgraduate physician training programs.

(v) Graduated repayment schedules are provided for the first time. The Committee anticipates that, under this provision, lenders may allow physicians to make larger payments on their loans during later periods in their careers when their incomes will be more predictable. In particular, the Committee hopes that sizable payments may be avoided in the first years of practice in which professional incomes may be relatively modest.

(vi) The maximum interest rate for HEAL loans is changed from 12 percent to the average of the bond equivalent rates of the 91-day Treasury bills option for the previous quarter, plus 2 percent. This provision is prompted by the recent experience with high interest rates and will allow the maximum for interest rates to fluctuate with the prevailing interest rates in the financial markets.

(vii) The provision which requires students to be enrolled at a school receiving capitation funds in order to receive HEAL loans is deleted.

(viii) The current requirement that only 50 percent of the students in any class at a school receive HEAL loans is removed. The Committee views the HEAL guarantees as last dollar financing and thinks that the amount available to any student should not be dependent upon the funds borrowed by other students at the same school.

PART C—INSTITUTIONAL SUPPORT

1. Background

In response to perceived critical health manpower shortages in the Nation, Congress in 1963 enacted legislation which provided direct Federal support for health professions education. For nearly two decades prior to this enactment, Federal funding for health professions education was byproduct of a direct commitment to biomedical research conducted by the National Institutes of Health.

In 1963 Congress sought to alleviate health manpower shortages by authorizing matching grants for construction, expansion, and remodeling and repair of health professions schools and by providing loans for students in three of the health professions schools (medicine, osteopathy, and dentistry). With the construction grant authority contained in this enactment, Public Law 88–129, Congress sought to alleviate shortages of health personnel by encouraging health professions schools to expand enrollments.

Shortages of health manpower were perceived to be no less critical in 1965 when Congress considered proposals which would extend and expand the 1963 authority. The Health Professions Educational Assistance Amendments of 1965, Public Law 88–290, extended the program of matching grants for the construction of teaching facilities for health professions training. It also introduced a program of formula grants, known as basic improvement grants, as well as a program of special improvement grants, to various health professions schools. By authorizing this new formula grant program and the special improvement grant program, Congress intended to offer another incentive to health

professions schools to further expand enrollments. It also intended that such funds serve to assure the financial solvency of schools experiencing shortages of operating funds.

Since the original authorization of the formula grant program in 1965, several changes in the formula—including increasing amounts per student and total sums authorized, as well as numbers of students counted for the purposes of determining grants awarded to schools—have been enacted. These formula grants were named "capitation" grants with the enactment of the Comprehensive Health Manpower Training Act of 1971, Public Law 92–157.

In 1971, at the time of the consideration of provisions revising the formula grant program to provide capitation grant assistance to health professions schools, the House Committee on Interstate and Foreign Commerce observed that a mechanism of assistance was required which, at one and the same time, would alleviate financial distress as well as provide a stabilizing basis for the educational programs of health professions schools.

> The capitation levels proposed in this bill are designed to significantly alleviate the financial distress of those schools which are in serious financial straits. Grants should enhance the ability of schools more fortunately situated to increase enrollments and make their curricula increasingly relevant to the health care needs of the Nation. The capitation grants are designed to provide a dependable support base for the educational programs of the health professions schools without having to go through the "back door" of research to support education. Special project assistance authorized elsewhere in the bill would provide additional assistance to those institutions which will respond further to the Nation's complex health manpower needs.[1]

As enacted, the Comprehensive Health Manpower Training Act of 1971, Public Law 92–157, authorized a program of capitation grants based upon statutorily determined amounts per student per year and a bonus for enrollment of first-year students beyond mandated levels. Schools of medicine, osteopathy, and dentistry were authorized to receive $2,500 for each first-, second-, and third-year student; $1,000 for each enrollment bonus student; $4,000 for each graduate completing studies in more than three years; and $6,000 for each student completing studies in three years or less.

Schools of pharmacy, optometry, and podiatry were authorized to receive $800 for each full-time student and $320 for each enrollment bonus student. Schools of veterinary medicine were authorized to receive $1,750 for each full-time student and $700 for each enrollment bonus student.

In order to receive capitation grants, schools were required to expand enrollment, maintain levels of non-Federal financial support, and submit plans assuring that they would conduct at least three of nine specified programs considered by the Congress as responsive to national needs. These ranged from projects to establish cooperative interdisciplinary training among health professions schools to proj-

[1] U.S. House of Representatives. Committee on Interstate and Foreign Commerce, Comprehensive Health Manpower Training Act of 1971. A Report to on H.R. 8629, H. Rept. No. 92–258, June 9, 1971, p. 28.

ects to increase enrollments of financially or educationally disadvantaged students. Separate authority was provided for financial distress grants to provide emergency financial assistance to schools experiencing acute financial difficulties despite capitation grant awards.

Health Professions Educational Assistance Act of 1976

By 1974, increasing levels of Federal support to health manpower training programs provided substantial increases in enrollments at health professions schools. In addition, the financial stability which formula grants and other institutional support programs were intended to assure for health professions schools also had become evident.

However, as the Congress began, in 1974, to consider revision and extension of health manpower training programs, the need to increase the aggregate supply of health personnel no longer commanded the concern it had in prior years. Rather, problems associated with the distribution of health professions—across the Nation geographically, and by specialty—were perceived by the Congress to be the issues requiring legislative response. The House Committee on Interstate and Foreign Commerce and the Senate Committee on Labor and Public Welfare agreed that capitation assistance might be targeted to address problems of geographic and specialty maldistribution.

The Committee on Interstate and Foreign Commerce observed that Federal support for health manpower training programs had always been tied to specific requirements which corresponded to perceived national needs:

> The Committee rejected the proposition advanced by representatives of health professions schools that every school should be entitled to a basic grant with bonuses for increased enrollment or projects of national significance. From the inception of Federal support for health professions schools, such support has always been tied to specific requirements. The Committee continues to believe that Federal support on such a substantial level should only be extended to those schools which agree to fulfill nationally perceived needs. The twin problems of overall shortages and geographic maldistribution of health personnel, discussed elsewhere in this report, which this Nation faces today cannot be solved by providing hundreds of millions of dollars to health professions schools without exacting some measure of compliance with their oft-voiced claim to being national resources.
>
> The Committee does not feel that the eligibility requirements proposed in this bill are onerous ones. Increased enrollment and maintenance of non-federal effort have long been requirements for Federal support of health professions schools in meeting the need for more manpower. Alternative requirements that medical, osteopathic, and dental schools conduct remote site training programs are in recognition of the national need to find solutions to the geographic maldistribution within these professions.[2]

[2] U.S. House of Representatives. Health Manpower Act of 1975. A Report to Accompany H.R. 5546, p. 19.

The House Committee proposed to continue funding for capitation for three years. It indicated, however, that a token reduction in such support for medical, dental, and osteopathic students was intended to serve notice to schools that capitation assistance, in perpetuity, should not be considered a foregone conclusion and that schools should assume more responsibility for seeking alternative sources of funding for their core medical education financial support.[3]

It was necessary for both the 93d and 94th Congresses to debate issues surrounding the extension of institutional support, as well as other programs of Federal assistance for health manpower training before these could be resolved in Public Law 94–484, for the House and the Senate had adopted distinctly different approaches to revisions which might address geographic and specialty distribution problems.[4]

For example, on the issue of tying capitation assistance to the problem of geographic maldistribution of health manpower, the House-passed bill, H.R. 5546 (94th Congress), required schools to enter into agreements with each student to repay, after graduation, the amount of capitation grants paid on behalf of the student in annual installments equal to the number of such grants. This provision permitted forgiveness of one annual installment for each year of service in the National Health Service Corps or Indian Health Service, in private practice for a designated medically underserved population, or in military service. Moreover, this bill required schools of medicine and osteopathy to meet one of two additional requirements: (1) to expand first- or third-year enrollments by a specified percentage or number; or (2) to have an approved plan to train, for at least six weeks prior to graduation, at least half of the school's students in ambulatory care settings in areas geographically remote from the main teaching site.

Under the Senate-passed bill, S. 3239 (94th Congress), schools of medicine and osteopathy were required to reserve a specified number of places for students who had applied for National Health Service Corps scholarships and had agreed in writing to accept such scholarship. Such scholarship assistance obligated students to service in a health manpower shortage area upon completion of training. In addition, schools of medicine were required to have a specified percentage of filled residencies in family practice, general internal medicine, general pediatrics, and general obstetrics and gynecology. By this latter provision, the Senate had intended to address the problem of specialty maldistribution in the medical profession.

In the end, the Congress agreed to the extension of several programs of institutional support for health professions schools. The capitation grant program was extended and expended to include schools of public health. Grants per student were specified for each of the health professions schools as follows: For schools of medicine, osteopathy and dentistry, $2,000 for fiscal year 1978 for each full-time student enrolled, $2,050 for fiscal year 1979, and $2,100 for fiscal year 1980; for schools of public health, $1,400 for each of the fiscal years 1978–80 for each

[3] Ibid., p. 20.

[4] The differing approaches adopted by the House and the Senate during the 94th Congress for targeted capitation assistance for the various health professions schools and for the other programs of institutional support are detailed in the comparative chart contained in the CRS document "Health Professions Educational Assistance Act of 1976."

full-time student and full-time student equivalent; for schools of veterinary medicine, $1,450 for each of the fiscal years 1978–80 for each full-time student; for schools of optometry, $765 for each of the fiscal years 1978–80; for schools of pharmacy, $695 for each of the fiscal years 1978–80; and for schools of podiatry, $965 for each of the fiscal years 1978–80.

In order to be eligible for capitation grants, schools were required by this enactment (1) to maintain first-year enrollments of full-time students at levels equal to the preceding year; and (2) to maintain expenditures of non-Federal funds at the preceding year's level. Additional requirements were specified for each of the health professions schools. Medical schools, for example, were required to have a specified percentage of filled first-year residency positions in primary care programs. In addition, they were required to increase third-year enrollments to accommodate students who were U.S. citizens and who were enrolled in foreign medical schools. Of those House-passed and Senate-passed provisions which were intended to address problems of the geographic and specialty maldistribution of physician manpower through the capitation grant program, the amended residency requirement was the only provision to emerge in the enacted legislation.

2. Need

Table 18 presents data on capitation grant assistance since 1972. Participating enrollments at each of the health professions schools are also indicated. This table shows, among other things, steadily increasing enrollments at each of the health professions schools. At schools of medicine, for example, participating enrollments increased by 43 percent between 1972 and 1979. Table 18 also shows a peaking of capitation grant assistance in 1974, with decreasing obligations and decreasing grants per student being awarded to each of the professional schools since then.

Table 19 presents similar data for schools of medicine, but in addition, indicates capitation grants per student in 1972 dollars. Between 1972 and 1979, capitation grants per medical student decreased by almost 50 percent in current dollars, and by nearly 70 percent in terms of 1972 dollars. It has been estimated that, for 1975–76, Federal capitation grants amounted to anly 3 percent of medical schools' total revenues.[5]

The Committee notes that even with such substantial reductions in capitation grant support, the Department awarded financial distress grants to only six health professions schools in fiscal year 1978; these grants amounted to $5 million and one institution (Meharry Medical College) received about 80 percent of the total.

---

[5] Perry, Donald R. and David R. Challover, "A Rationale for Continued Federal Support of Medical Education," The New England Journal of Medicine, January 11, 1979, p. 67.

TABLE 18.—CAPITATION GRANTS TO HEALTH PROFESSIONS SCHOOLS, FISCAL YEAR 1972–79—TOTAL OBLIGATIONS, PARTICIPATING ENROLLMENT, AND CAPITATION GRANT PER STUDENT [1]

Type of school	1972 [2]			1973 [2]			1974 [2]			1975		
	Total grants (thousands)	Participating enrollment	Grant per student	Total grants (thousands)	Participating enrollment	Grant per student	Total grants (thousands)	Participating enrollment	Grant per student	Total grants (thousands)	Participating enrollment	Grant per student
Medicine	$90,191	43,276	$2,084	$95,885	47,107	$2,035	$105,604	50,437	$2,094	$85,818	53,564	$1,602
Osteopathy	4,821	2,306	2,091	5,763	2,565	2,247	6,505	2,773	2,346	5,405	3,118	1,733
Dentistry	34,988	16,667	2,099	36,852	18,125	2,033	40,391	19,130	2,111	31,777	19,847	1,599
Optometry	2,171	3,094	702	2,211	3,313	667	2,515	3,532	712	2,016	3,704	544
Pharmacy	15,102	22,449	673	16,556	23,560	703	20,283	26,244	773	16,753	28,255	593
Podiatry	956	1,267	755	1,062	1,403	757	1,359	1,630	834	1,219	1,836	664
Veterinary medicine	6,970	4,538	1,536	7,571	5,189	1,459	8,881	5,752	1,544	7,012	6,012	1,166
Public health												
Total	155,199			165,900			185,538			150,000		

Type of school	1976			1977			1978			1979		
	Total grants (thousands)	Participating enrollment	Grant per student	Total grants (thousands)	Participating enrollment	Grant per student	Total grants (thousands)	Participating enrollment	Grant per student	Total grants (thousands)	Participating enrollment	Grant per student
Medicine	$57,511	55,659	$1,033	$69,955	57,457	$1,217	$85,290	61,356	$1,390	$66,500	62,044	$1,072
Osteopathy	3,876	3,438	1,127	4,895	3,675	1,331	5,890	4,237	1,390	6,400	5,985	1,072
Dentistry	21,514	20,142	1,068	25,231	20,419	1,235	27,720	19,941	3,390	23,200	21,606	1,072
Optometry	1,394	3,944	354	1,360	4,031	337	1,725	4,458	386	1,360	4,545	299
Pharmacy	11,074	28,572	388	10,640	30,749	346	9,495	27,019	351	7,600	27,702	274
Podiatry	911	2,081	438	976	2,290	426	1,221	2,502	448	960	2,580	372
Veterinary medicine	4,821	6,252	771	4,845	6,549	739	5,379	7,334	733	4,480	7,820	573
Public health							5,841		839	5,900		811
Total	101,101			117,902			142,561			116,400		

[1] Department of Health, Education, and Welfare, unpublished data.

[2] Includes enrollment bonus students.

TABLE 19.—CAPITATION AWARDS—U.S. MEDICAL SCHOOLS[1]

	Total award (millions)		Per medical student	
	MOD schools	Medical schools	Current dollars	1972 dollars
Fiscal year:				
1972	$130.0	$90.2	2,065	2,065
1973	138.5	95.9	2,015	1,900
1974	152.5	105.6	2,075	1,790
1975	122.4	85.5	1.585	1.250
1976	82.9	57.5	1,030	770
1977	101.1	70.0	1,210	850
1978	120.1	85.3	1,370	900
1979[2]	96.1	66.5	1,070	650

[1] Unpublished data furnished by the Association of American Medical Colleges.
[2] Represents awards at the rescinded amounts; actual appropriation for 1979—MOD $120,000,000, schools of medicine $86,300,000, per medical student $1,325.

In its report on the Health Professions Education Assistance Act of 1976, this Committee recommended to schools of medicine, osteopathy, and dentistry that they should assume more responsibility for seeking alternative sources of funding for their core medical education financial support. The committee notes that the relative contribution of the various sources of revenues for medical schools have indeed changed as Federal support has decreased.

Table 20 provides information on sources of revenue for U.S. medical schools. Table 20 indicates that Federal dollars (both research and direct operational support) amounted to about 55 percent of total revenues to medical schools in 1965–66, and 37 percent in 1975–76. Funds from State and local Governments increased from 16 to 27 percent of total revenues during this period, with about 90 percent of these funds going to State public medical schools as operating support.[6]

TABLE 20.—SUMMARY OF FINANCIAL SUPPORT FOR U.S. MEDICAL SCHOOLS, 1960–61 TO 1975–76

[Dollar amounts in millions][1]

	1960–61		1965–66		1970–71		1975–76	
Number of schools	87		87		95		113	
Number of schools reporting	87		87		92		109	
	Amount	Percent[2]	Amount	Percent[2]	Amount	Percent[2]	Amount	Percent[2]
Revenues:								
Federal Government	$181	42	$481	55	$779	45	$1,206	37
State/local government	81	19	143	16	385	23	937	27
Nongovernment[3]	118	27	156	18	312	18	507	15
Medical school/university activities[4]	55	13	102	12	237	14	622	19
Total	435	100	882	100	1,713	100	3,272	100

[1] "Medical Education: Institutions, Characteristics and Programs," Association of American Medical Colleges, June 1977 p. 37.
[2] Percentages will not equal 100 when added due to rounding.
[3] Includes endowment income, gifts, and revenue from miscellaneous sources.
[4] Includes revenue from medical service plans, tuition and fees, general university funds supporting the medical school, and income from college services.

Tables 21 and 22 detail, by State, State funds awarded to public and private medical schools for educational and general purposes for fiscal years 1973 and 1976. During this period, aggregate State funds

[6] Perry and Challover, p. 67.

for medical schools increased by approximately 77 percent and the mean grant per student increased by nearly 70 percent.

One other source of revenues for medical schools is service-plan income generated from the practice of clinical faculty at medical schools. Table 23 details the increase which has occurred in service-plan income. In 1965–66, medical service-plan income accounted for 3 percent of reported revenues of medical schools. By 1975–76, this income had increased to 12 percent of total revenues. Perry and Challover in their New England Journal of Medicine article, "A Rationale for Continued Federal Support of Medical Education," note that 12 percent of total revenues is probably an underestimate of practice income because of imperfections in many schools' methods of accounting for faculty clinical activities.[7]

Table 23 also provides information on the relative contribution of tuition to medical schools' revenues. The table indicates that the relative contribution of this source of funds to medical school revenues has remained essentially unchanged between 1965–66 and 1975–76—between 4 and 5 percent.

[7] Ibid.

TABLE 21.—STATE FUNDS FOR PUBLIC AND PRIVATE MEDICAL SCHOOLS FOR EDUCATIONAL AND GENERAL PURPOSE PROGRAMS [1]

State	Public medical schools		Private medical schools (thousands)
	Total (thousands)	Per FTE student [2]	
FISCAL 1973 [3]			
Alabama	$8,462	$7,610	
Arizona	6,988	13,311	
Arkansas	2,785	3,675	
California	41,615	5,700	
Colorado	4,561	3,379	
Connecticut	4,945	11,164	
Florida	19,124	9,875	$2,997
Georgia	8,411	9,243	195
Illinois	18,402	9,147	3,617
Indiana	7,886	3,244	
Iowa	6,628	4,271	
Kentucky	9,181	5,761	
Louisiana	7,820	6,062	
Maryland	4,781	4,087	800
Massachusetts	3,436	18,086	
Michigan	28,311	5,034	
Minnesota	4,441	1,298	288
Mississippi	4,211	5,956	
Missouri	6,426	4,814	
Nebraska	4,077	3,925	
Nevada	47	395	
New Hampshire			149
New Jersey	14,256	11,315	
New Mexico	2,400	5,206	
New York	25,377	4,593	9,957
North Carolina	8,613	6,282	683
Ohio	16,160	3,477	2,250
Oklahoma	3,829	2,879	
Oregon	5,432	5,030	
Pennsylvania	11,979	3,799	8,497
Puerto Rico	2,764	2,697	
Rhode Island			200
South Carolina	8,870	8,541	
South Dakota	908	4,782	
Tennessee	3,983	2,430	
Texas	36,998	12,470	4,583
Utah	2,564	2,619	
Vermont	2,170	2,830	
Virginia	9,729	4,653	
Washington	7,727	3,034	
West Virginia	3,618	4,675	
Wisconsin	4,798	3,045	1,876
Total	364,623		36,092
Mean		5,760	
S.D.		3,643	

[1] The data relate to funds provided directly by the State to medical schools located within the State and, in the case of Pennsylvania, to State-related medical schools. They exclude funds provided to medical schools through regional compacts. Data are not available for State support provided to medical schools in Hawaii, Kansas, and North Dakota. The fiscal 1973 State support data are derived from the 1973 Annual Medical School Questionnaire of the Liaison Committee on Medical Education, supplemented or amended by information provided directly by the medical school. Funds per resident of the State are based on 1972 population data taken from the "Statistical Abstract of the United States," 1973, 94th annual edition, p. 13. Personal income data are preliminary 1973 figures from the "Survey of Current Business," April 1974, vol. 54, No. 4, p. 17. FTE student data are taken from the "Journal of the American Medical Association," vol. 226, No. 8, Nov. 19, 1973, pp. 1000–1001. Population and present income data for Puerto Rico were obtained from the Washington, D.C., office of the government of Puerto Rico.

[2] FTE students include all full-time medical students, master's and Ph. D. candidates, interns, residents, postdoctoral students, fellows, and a calculated full-time student equivalent for all other students educated by the medical school.

[3] "State Roles in Financing Medical Education," Journal of Medical Education, vol. 49, No. 12, December 1974, p. 1194.

TABLE 22.—STATE FUNDS FOR PUBLIC AND PRIVATE SCHOOLS FOR EDUCATIONAL AND GENERAL PURPOSE PROGRAMS

State (territory)	Public medical schools		Private schools total (thousands)
	Total (thousands)	Per student	
FISCAL 1976[2]			
Alabama	$22,579	$16,314	----
Arizona	8,672	13,424	----
Arkansas	5,417	6,679	----
California	63,497	8,732	----
Colorado	6,632	5,113	----
Connecticut	8,706	14,731	----
Florida	15,249	12,278	$4,144
Georgia	11,342	15,452	----
Hawaii	4,577	7,988	----
Illinois	41,980	17,781	5,880
Indiana	12,648	6,785	----
Iowa	6,236	4,328	----
Kansas	15,799	14,376	----
Kentucky	15,006	8,055	----
Louisiana	13,206	9,892	605
Maryland	6,856	5,502	211
Massachusetts	7,719	16,251	----
Michigan	38,959	9,167	----
Minnesota	14,135	5,989	1,304
Mississippi	8,825	9,894	----
Missouri	10,209	8,341	----
Nebraska	8,223	9,697	----
Nevada	1,159	8,522	----
New Hampshire	----	----	75
New Jersey	21,118	11,191	----
New Mexico	4,026	7,525	----
New York	48,427	12,229	14,742
North Carolina	13,940	11,884	1,917
North Dakota	3,596	13,124	----
Ohio	23,024	7,659	3,939
Oklahoma	6,544	5,864	----
Oregon	10,904	11,418	----
Pennsylvania	----	----	[3] 25,026
Puerto Rico	2,846	3,775	----
Rhode Island	----	----	700
South Carolina	12,868	11,871	----
South Dakota	1,999	9,474	----
Tennessee	7,389	5,229	200
Texas	89,252	20,443	9,764
Utah	3,740	4,255	----
Vermont	2,851	5,109	----
Virginia	17,167	7,262	410
Washington	10,032	6,489	----
West Virginia	8,655	12,525	----
Wisconsin	9,461	6,584	2,503
Total	645,470	409,201	71,420
Mean	15,368	9,743	----
Median	9,746	8,950	----

[1] Amounts provided by State legislature to schools located within the State less tuition or other income flows to the medical school which revert to the State government.
[2] "State Roles in Financing Medical Education," Journal of Medical Education, vol. 52, No. 7, July 1977, p. 608.
[3] Includes State-related medical schools.

TABLE 23.—REVENUES FOR THE GENERAL OPERATIONAL PROGRAMS OF U.S. MEDICAL SCHOOLS, 1960–61 TO 1975–76

[Dollar amounts in millions][1]

	1960–61		1965–66		1970–71		1975–76	
Number of schools	87		87		95		113	
Number of schools reporting	87		87		92		109	
	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent
Total source of expended revenues	$436	100.0	$882	100.0	$1,713	100.0	$3,273	100.0
Sponsored program revenues	222	50.9	514	58.3	933	54.5	1,534	46.9
General operating revenues	214	49.1	368	41.7	780	45.5	1,739	53.1
State and local government	69	15.8	120	13.5	285	16.6	712	21.8
Appropriations	60	13.7	112	12.7	263	15.3	627	19.2
Subsidies	9	2.1	8	.9	23	1.3	85	2.6
Medical service plans	13	3.0	25	2.9	115	6.7	383	11.7
Recovery of indirect costs	19	4.3	59	6.7	101	5.9	216	6.6
Federal Government	17	3.9	54	6.1	89	5.2	197	6.0
State and local government	1	.3	2	.2	5	.3	7	.2
Non-Government	1	.1	3	.3	6	.4	12	.4
Tuition and fees	28	6.5	41	4.6	63	3.7	146	4.4
Unrestricted endowment income	17	3.9	26	3.0	36	2.1	50	1.5
Unrestricted gifts	11	2.5	14	1.6	20	1.2	29	.9
Income from college services	8	1.8	31	3.5	24	1.4	62	1.9
General university funds	6	1.3	22	2.5	34	2.0	32	1.0
Miscellaneous sources	45	10.2	30	3.4	100	5.8	107	3.3

[1] "Medical Education: Institutions Characteristics and Programs," Association of American Medical Colleges, June 1977, p. 39.

Note: Revenues are restricted to expenditures for a specific program. Revenues are approximately equal to expenditures.

3. Proposed legislation

As reported from the Committee on Interstate and Foreign Commerce, H.R. 7203 would: (1) provide a phase-down in the institutional support grant program (capitation) over the next three fiscal years for most of the health professions schools; (2) exclude Schools of Public Health and Schools of Nursing from that phase-down process; (3) retain all existing requirements for eligibility for institutional support grants except: (a) the current generic maintenance of enrollment provision, and (b) the current requirement that a private nonprofit School of Optometry must enroll 50 percent of its first year students from states without accredited Schools of Optometry if it elects that option to establish eligibility for institutional grant support (the percentage figure is reduced to 25 percent to correspond to the current requirement for public Schools of Optometry); and (4) provide that no institution affected by these amendments would be eligible to receive institutional grant support (capitation) in future years unless: (a) it received such support in fiscal year 1980, and (b) the total appropriations of funds for that type of health professions institution exceeds the comparable appropriation for fiscal year 1980.

As the Committee noted in 1976, and reiterates today, it rejects the proposition that every school should be entitled to unconditional basic institutional support. From its inception, Federal support has been tied to specific requirements. In this Committee's report on the Health

Professions Educational Assistance Act of 1976, the health professions institutions were advised to seek alternative sources of funding for basic educational support. The Committee is pleased to note that this has indeed occurred. In an effort to provide an orderly transition from existing Federal support to other forms of basic aid, the Committee has proposed authorizations of appropriations for the various types of health professions institutions which approximate 75 percent, 50 percent, and 25 percent of the fiscal year 1980 appropriations for such institutions, for fiscal years 1981, 1982, and 1983, respectively. The Committee believes this to be the most reasonable and responsible fashion in which to complete such a transition.

For that reason, the Committee has rejected the proposal advanced by the Department of Health and Human Services to terminate the institutional support (capitation) grant program at this time. The Committee has also excluded Schools of Public Health and Schools of Nursing from both the proposed 'phase-down' and the proposed prohibition of new support for schools not currently receiving assistance under this program. In each instance, the Committee feels that the continuing need for additional graduates from such programs is well documented, and that the anticipated income levels of such health professionals warrant continued Federal basic institutional support.

The Committee's proposal to remove the generic maintenance of enrollment requirement which currently exists as a prerequisite to eligibility for institutional support (capitation) grants, is consistent with the Committee's view that enrollment increases stimulated by past health manpower legislation have produced levels at which continued growth in many professional areas is no longer necessary. However, because both faculty and facilities are now in place to train a certain number of health professionals each year, the Committee expects that the practical effect of the deletion of this requirement on the actual number of health professionals graduated in future years will be minimal.

Finally, the Committee proposal authorizes the Secretary to disregard enrollment increases in Schools of Medicine which were made to enable such schools to qualify for a special assistance program of the Veterans' Administration, when assessing such schools' efforts at maintenance of enrollment to determine eligibility for the award of capitation grants in fiscal year 1980. It is not this Committee's intent that a School of Medicine be penalized in its institutional support program because it particiapted in another Federally sponsored effort.

PART D—PROJECT GRANTS AND CONTRACTS

1. Background

In the Health Professions Educational Assistance Amendments of 1965, Congress established a program of formula grants, known as basic improvement grants, as well as a program of special improvement grants, to various health professions schools. These basic and special improvement grants were intended by the Congress to encourage expanded enrollments at various health professions schools and to ensure the financial solvency of schools experiencing shortages of operating funds.

In its 1965 report, the Committee detailed the purpose which it anticipated basic and special improvement grants would serve for health professions schools. For inadequately supported schools, basic improvement grants were expected to be used for improving critical weaknesses in the basic components of professional education. More adequately supported schools were expected to use these grants for such things as achieving balance in curriculum areas and experimenting with innovations in professional health education. Special improvement grants were expected to narrow the gap in the quality of education provided by individual schools since they would be awarded on the basis of need.[1]

In addition, the Committee suggested that such grants would serve another useful purpose. They would strengthen teaching programs "which have tended to be neglected" in favor of sponsored research programs.[2]

Special improvement grants would be awarded from appropriated sums not used for basic improvement grants and could be used only for providing or assuring maintenance of accreditation and for the schools' specialized functions. Special improvement grants were limited per school to $100,000 for fiscal year 1966; $200,00 for fiscal year 1967; $300,000 for fiscal year 1968; and $400,000 for fiscal year 1969.

In 1968, Congress revised both the basic and special improvement grant programs. Under the Health Manpower Act of 1968, special improvement grants were renamed special project grants, and various new purposes were specified for the use of this assistance. These included programs which would effect significant improvements in the curricula of health professions schools, develop training for new levels or types of health professions personnel, assist schools in serious financial distress, and establish new programs of education or strengthen and improve existing programs for the training of health professionals. The Congress intended, however, that among these several purposes, priority would be given to grants for schools in financial difficulty. The Committee stated:

> One of the principal purposes of the special project grant is the assistance—even the saving—of health professions schools in serious financial difficulties.
>
> This is predicated on the fact that it is less costly, particularly with respect to time, to assist a school to continue its operation than to permit it to close and replace it with a new school at a cost of many millions of dollars, and a loss of as many as 10 years of output of graduates. To say that it is "less costly" should not, however, be interpreted as being "inexpensive." [3]

In 1971, Congress extended and expanded the special project grant authority. With the enactment of the Comprehensive Manpower Training Act of 1971, Public Law 92–157, specific authority was provided for project grants in a number of areas. The areas reflect the fact that, in addition to a general concern with shortages of health personnel

[1] U.S. House of Representatives. Committee on Interstate and Foreign Commerce. Health Professions Educational Assistance Amendments of 1965. A Report on H.R. 3141, H. Rept. No. 781, August 12, 1965, p. 15.
[2] Ibid., p. 18.
[3] U.S. House of Representatives. Committee on Interstate and Foreign Commerce, Health Manpower Act of 1968, p. 31–32.

and the financial stability of the various health professions schools, the Congress also was concerned with the distribution of physicians across specialties and throughout the nation geographically.

Project grant authorities established by the 1971 statute in order to correct problems associated with the maldistribution of health professionals include a separate authority for Health Manpower Education Initiative Awards. One of the purposes of this grant program was to encourage the establishment of Area Health Education Centers (AHECs) located in areas removed from the principal training center of the school and in areas with shortages of health personnel. Such centers were intended by the Committee to improve the distribution and supply of health manpower in such areas, as well as to attract health care personnel to establish practices in these areas.[4]

Another program of grants was authorized by Public Law 92–157 for the establishment and operation of training programs in family medicine, as well as for traineeships and fellowship for students of family medicine. With this program, Congress intended to increase the availability of primary health care services in the Nation.

In the 1971 legislation, Congress also sought to improve the representation of minority and low-income students in health professions schools. A purpose of the Health Manpower Education Initiative Awards was to encourage and assist increased numbers of individuals from minority or low-income groups to undertake training in and successfully complete professional courses of study in health professions schools and encourage the enrollment of students likely to practice in rural or other areas having a shortage of such personnel.

Public Law 92–157 also provided authority for: financial distress grants to provide emergency financial assistance to schools experiencing acute grants to provide emergency financial assistance to schools experiencing acute financial difficulties, despite capitation grant award assistance; start-up grants for new schools of medicine, dentistry, and osteopathy; and conversion grants for two-year schools of basic medical service which desired to become accredited, degree-granting schools of medicine.

2. Current Project Grants and Contracts Programs

The Health Professions Educational Assistance Act of 1976, Public Law 94–484, extend and revised the several authorities for special grants established in 1971. The revised authorities were consolidated in a new Part F of Title VII, Grants and Contracts for Programs and Projects. Among other things, this new part contained separate authorities and specifications for: (1) project grants for the establishment of departments of family medicine; (2) grants for programs to train physician assistants and dental auxiliaries; (3) grants for training programs in family medicine and the general practice of dentistry: (4) grants for area health education centers; (5) educational assistance to individuals from disadvantaged backgrounds; and (6) grants for start-up assistance, financial distress, interdisciplinary training, and curriculum development.

The following tables details funds awarded for these various special project authorities in the past three fiscal years.

---

[4] U.S. House of Representatives. Committee on Interstate and Foreign Commerce, Comprehensive Health Manpower Training Act of 1971, p. 33–34.

TABLE 24.—NUMBER OF SPECIAL PROJECTS AWARDED TO HEALTH PROFESSIONS SCHOOLS, AND AMOUNT AWARDED, BY TYPE OF PROJECT, FISCAL YEARS 1977–79 [1]

[Dollar amounts in thousands]

Project	1977		1978		1979	
	Number awarded	Amount awarded	Number awarded	Amount awarded	Number awarded	Amount awarded
1. Project grants for the establishment of departments of family medicine	[2]	[2]	0	0	0	0
2. Area health education centers	[2]	[2]	33	$17,000	21	$20,000
3. Education of returning U.S. students from foreign medical schools	8	$600	18	1,000	18	1,000
4. Programs for:						
(a) Physician assistants	[2]	[2]	46	8,700	46	8,600
(b) Expanded function dental auxiliaries	[2]	[2]	21	2,300	24	2,000
(c) Dental team practice	[2]	[2]	24	[3] 4,100	11	2,000
5. Grants for training, traineeships, and fellowships in general internal medicine and general pediatrics	47	7,100	86	14,500	88	17,200
6. Occupational health training and education centers	[4]	[4]	[4]	[4]	[4]	[4]
7. Programs for:						
(a) Family medicine	[2]	[2]	285	41,600	236	40,000
(b) General practice of dentistry	[2]	[2]	32	3,400	46	4,500
8. Educational assistance to individuals from disadvantaged backgrounds	[2]	[2]	142	15,000	151	19,000
9. Project grant authority for:						
(a). Start-up assistance	[2]	[2]	11	[5] 5,000	16	5,000
(b) Financial distress	[2]	[2]	6	[6] 5,000	7	5,000
(c) Interdisciplinary training and curriculum development	[2]	[2]	37	3,900	61	[7] 7,900
10. Grants for planning costs for projects to train medical school students	0	0	[2]	[2]	[2]	[2]
11. Grants for the development of new medical schools emphasizing training in family medicine	0	0	0	0	[2]	[2]

[1] These special projects are only those authorized under Public Law 94–484, Health Professions Educational Assistance Act of 1976.
[2] Not authorized.
[3] $500,000 reprogramed.
[4] The Bureau of Health Manpower delegated authority for this program to the National Institute for Occupational Safety and Health (NIOSH) However, NIOSH has never used that authority. Instead, NIOSH funds education resource centers under the authority of the Occupational Safety and Health Act of 1970.
[5] $3,000,000 reprogramed.
[6] $2,000,000 reprogramed.
[7] $800,000 reprogramed.

Source: Office of Financial Management, DHHS, HRA, BHM.

3. Need

a. Primary care

In 1966, the publication of the report of the Citizens Commission on Graduate Medical Education (the Millis Report) directed the Nation's attention to the decreasing number of general practitioners in the country as increasing numbers of medical school graduates entered residency training programs in one of the medical specialties. The Commission had been established, in part, because "as yet no serious effort has been made to determine, even in general terms, the distribution of physicians within the differing fields of medical practice which would be optimal for the provisions of superior medical service."

The Millis Report observed in its findings that "the general practitioner leaves behind him a vacuum that organized medicine has not decided how to fill."

> One result of this vacuum has been that the patient becomes his own diagnostician, and decides which kind of specialist he should approach. Or he seeks the advice of a pharmacist or a friend, or follows his own ideas of what constitutes proper treatment. Other patients—in increasing numbers—take their problems to the hospital emergency room. It is always open; all are received; and good medical care and facilities are there available, at least for emergencies. This solution, however, offers little continuity, and the relationship is less than satisfactory either to the patient or the hospital staff.[5]

The Commission called for the training of "primary physicians" and cited several reasons which might explain declining numbers of such psysicians in practice:

> 1. General practice, once the mainstay of medicine, has gradually lost prestige as the specialties have risen in honor and accomplishments. In deciding upon his own career, the young physician may never see excellent examples of comprehensive continuing care or highly qualified and prestigious primary physicians. He is certain however, to see a variety of specialists and to observe that they usually enjoy higher prestige, greater hospital privileges, and more favorable working conditions than do general practitioners.
>
> 2. Educational opportunities that would serve to interest students in family practice and provide interns and residents with appropriate training are few in number and often poorer in quality than the programs leading to the specialities.
>
> 3. The conditions of practice for a general practitioner or a physician interested in family practice are thought to be less attractive than the conditions and privileges enjoyed by a specialist.[6]

Since the Commission's Report, the concept of a "primary physician" has evolved into the concepts of the "primary care physician" and "primary care services." E. Harvey Estes, Chairman of the Institute of Medicine Study, A Manpower Policy for Primary Health Care, has defined primary care as a set or an array of services, usually provided by a physician and a team of other individuals, usually in a variety of locations, including home, office, and hospital.[7] According to Dr. Estes, good primary care is accessible, comprehensive, coordinated, continuous, and accountable.

> The first adjective describing good primary care is accessible. Patients should be able to reach their doctor, or a member

---

[5] The Graduate Education of Physicians, the Report of the Citizens Commission on Graduate Medical Education Commissioned by the American Medical Association, August 1966. p. 34.

[6] Ibid., p. 39, 40.

[7] Testimony offered by E. Harvey Estes, M.D., Chairman, Department of Community and Family Medicine, Duke University, to the Subcommittee on Health and the Environment of the House Committee on Interstate and Foreign Commerce, Mar. 24, 1980.

of the team, at all times. In addition the location of the services should be such that patients can reach them, and the facilities should be such that they are comfortable and pleasant.

The second adjective is comprehensive. The great majority (about 90 percent) of the problems presented by the patient should be handled by the primary care team. These services might range from general preventive exams to the handling of minor trauma. The rest of the problems are, of course, referred to an appropriate secondary or tertiary level of care. The third adjective is coordinated. The primary care doctor should be a manager of the patient's medical and health problems, providing information to specialists, receiving information back from specialists and interpreting this to the patient. He should answer for the patient those questions about choice of treatment, life habits, etc. which all patients have.

The fourth adjective is continuous. Primary care should provide continuity over time. Even if a patient is referred, the doctor should seek out the results of the referral, and incorporate this information into the patient's record and into his/her own store of knowledge. Unnecessary referral to emergency rooms or other providers destroys continuity.

The fifth and last adjective is accountable. Primary care should take the lead in examining its own practices and care, should be honest and forthright with the patient, and should otherwise make the patient a partner in the process.

To date, no published studies have conclusively established or defined the extent to which shortage of primary care physicians exists in the country. Rather, as the GAO report, Art Enough Physicians of the Right Types Trained in the United States, has pointed out, there is a consensus of a need to train more such physicians based on:

Statistics showing a steady decline in the percentage of practicing physicians engaged in primary care since 1931;

Comparisons with the number of practicing primary care physicians in other countries, notably the United Kingdom where most physicians have been trained as general practitioners; and

Observation that a primary care physician can treat the vast majority of problems for which people seek care.[8]

With regard to the changing distribution of physicians across various specialties, table 25 below presents data for the period 1965 through 1977. This table shows that physicians in general and family practice decreased in number and in terms of their ratio to the population during this period. Physicians in surgical specialties increased by 38 percent between 1965 and 1977, and, in terms of their ratio to the population, by 24 percent. The ratio of physicians in medical specialties to the population increased by nearly 54 percent and the ratio of physicans in the category "other specialties" increased by 17 percent.

[8] Are Enough Physicians of the Right Types Trained in the United States, A Report to the Congress by the Comptroller General, May 16, 1978, pp. 11, 111.

TABLE 25.—NUMBER OF ACTIVE PHYSICIANS (M.D.'S) AND PHYSICIAN-TO-POPULATION RATIOS, BY GENERAL AND SPECIALTY PRACTICE: SELECTED YEARS, DEC. 31, 1965 TO 1977 [1 2]

Type of practice	1965 [3]		1970		1975		1977	
	Number	Physicians per 100,000 population	Number	Physicians per 100,000 population	Number	Physicians per 100,000 population	Number	Physicians per 100,000 population
All active	277,575	139.9	310,845	148.7	340,280	156.1	363,619	164.2
General and family practice [4]	64,943	32.6	57,948	27.7	54,557	25.0	55,159	24.9
Medical specialities	61,43	31.0	77,214	36.9	95,087	43.6	105,698	47.7
Alergy	1,541	.8	1,719	.8	1,716	.3	1,681	.8
Cardiovascular diseases	4,311	2.2	6,476	3.1	6,933	3.2	7,190	3.2
Dermatology	3,407	1.7	4,003	1.9	4,661	2.1	4,907	2.2
Gastroenterology	1,344	.7	2,010	1.0	2,381	1.1	2,620	1.2
Internal medicine	33,892	17.0	41,872	20.0	54,331	24.9	61,830	27.9
Pediatric allergy	270	.1	391	.2	446	.2	492	.2
Pediatric cardiology	311	.2	487	.2	533	.2	575	.3
Pediatrics	14,225	7.2	17,941	8.6	21,746	10.0	23,959	10.8
Pulmonary diseases	2,104	1.1	2,315	1.1	2,335	1.1	2,444	1.1
Surgical specialities	73,185	36.7	86,042	41.1	96,015	44.1	101,153	45.6
General surgery	25,643	12.9	29,761	14.2	31,562	14.5	32,340	14.6
Neurological surgery	2,041	1.0	2,578	1.2	2,926	1.3	3,071	1.3
Obstetrics and gynecology	10,379	8.2	18,876	9.0	21,731	10.0	23,376	10.6
Ophthalmology	8,380	4.2	9,927	4.7	11,129	5.1	11,606	5.2
Orthopedic surgery	7,557	3.8	9,620	4.6	11,379	5.2	12,323	5.6
Otolaryugology	4,851	2.4	5,409	2.6	5,745	2.6	5,980	2.7
Plastic surgery	1,167	.6	1,600	.8	2,236	1.0	2,522	1.1
Colon and rectal surgery	715	.4	667	.3	661	.3	657	.3
Thoracic surgery	1,473	.7	1,809	.9	1,979	.9	2,048	1.0
Urology	4,979	2.5	5,795	2.8	6,673	3.1	7,130	3.2

Other specialties	78,012	39.1	89,641	42.8	94,621	43.4	101,609	45.9
Aerospace medicine	1,603	.8	1,188	.6	684	.3	647	.3
Anesthesiology	8,592	4.3	10,860	5.2	12,861	5.9	13,918	6.3
Child psychiatry	1,154	.6	2,090	1.0	2,581	1.2	2,902	1.3
Neurology	2,198	1.1	3,074	1.5	4,131	1.9	4,628	2.1
Occupational medicine	2,801	1.4	2,713	1.3	2,355	1.1	2,149	1.0
Pathology [5]	8,233	4.1	10,483	5.0	11,910	5.5	12,567	5.7
Physicial medicine and rehabilitation	1,162	.6	1,479	.7	1,664	.8	1,792	.8
Psychiatry	17,333	8.7	21,146	10.1	23,922	11.0	24,894	11.2
Public health [6]	3,988	2.0	3,833	1.8	3,454	1.6	3,037	1.4
Radiology [7]	9,685	4.9	13,360	6.4	16,240	7.5	17,727	8.0
Other and unspecified	21,262	10.7	19,415	9.3	14,319	6.8	17,348	7.8

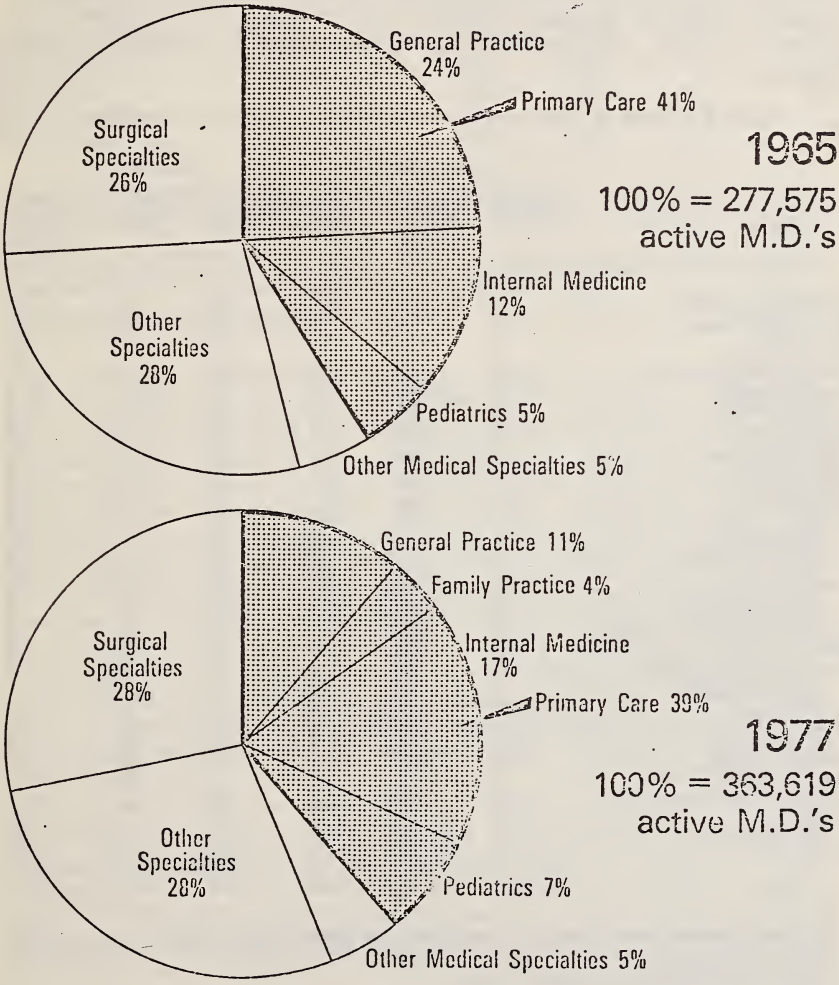
[1] Includes physicians in Federal service; also includes physicians in U.S. possessions.
[2] Ratios are based on total population plus civilian population in U.S. possessions.
[3] Because of a change in the AMA classification procedure, 1965 data have been adjusted to be comparable to data for the later years.
[4] Family practice is included beginning in 1970.
[5] Includes forensic pathology.
[6] Includes general preventive medicine.
[7] Includes both diagnostic and therapeutic radiology.

Source: Unpublished data, DHHS, HRA, BHM, January 1980. American Medical Association, Center for Health Services Research and Development. "Physician Distribution and Medical Licensure in the United States, 1977." Also prior annual issues for 1970 and 1975 data. 1965 adjusted data are from the American Medical Association report "Reclassification of Physicians, 1968."

The following chart 1 indicates growth in the supply of primary care physicians relative to growth in other specialties for the years 1965 and 1977. As this chart indicates, the supply of primary care physicians declined as a proportion of total active M.D.'s during the 1965 to 1977 period. In 1977, primary care physicians constituted 39 percent of total active M.D.'s; while in 1965, they had constituted 41 percent of the total. The supply of physicians in surgical specialties had grown at a faster rate, so that, by 1977, they constituted 28 percent of total active M.D.'s. In 1965, their share of total active M.D.'s amounted to 28 percent.

Chart 1

TREND IN NUMBER OF ACTIVE PHYSICIANS (M.D.'s) ENGAGED IN PRIMARY CARE AND OTHER MEDICAL SPECIALTIES, 1965 AND 1977



Source: Unpublished data, DHHS, HRA, BHM, January 1980.

The distribution of physicians across specialties is, in part, a function of the availability of residency training programs for a given specialty. Table 26 provides data on the number of accredited residency programs, as well as residents in various specialty training programs, for two years—1976 and 1979. Between 1976 and 1979, the number of accredited residency training programs in family practice/general practice increased from 346 to 366. Residents in training in that specialty increased from 8.3 percent of the total residents in 1976 to 10 percent in 1979. Note that as a percent of total residents, residents in internal medicine increased slightly and residents in pediatrics remained virtually unchanged, actually decreasing by one-tenth of one percent.

TABLE 26.—NUMBER OF ACCREDITED RESIDENCY PROGRAMS BY SPECIALTY OF PROGRAM

Specialty	September 1976 [1]			October 1979 [2]		
	Number of approved programs	Residents in specialty September 1976	Percent of total residents	Number of accredited programs	Residents in specialty July 1979	Percent of total residents
Allergy and immunology	6	22	0.04	46	132	0.2
Anesthesiology	160	2,252	3.7	163	2,473	3.8
Colon and rectal surgery	21	33	.05	27	44	.1
Dermatology	97	764	1.3	97	789	1.2
Dermatopathology	9	4	(3)	14	15	(3)
Family practice/general practice	346	5,015	8.3	366	6,420	10.0
Internal medicine	434	15,367	25.4	443	16,531	25.8
Neurological surgery	95	561	.9	94	547	.9
Neurology	121	1,161	1.9	120	1,220	1.9
Nuclear medicine	74	128	.2	89	165	.3
Obstetrics/gynecology	312	3,899	6.4	306	4,587	7.1
Ophthalmology	170	1,563	2.6	163	1,509	2.3
Orthopedic surgery	196	2,385	3.9	188	2,478	3.9
Otolaryngology	114	886	1.5	117	1,014	1.6
Pathology	392	2,756	4.6	358	2,499	3.9
Blood banking	7	4	(5)	18	21	(3)
Forensic pathology	30	24	.04	36	24	(3)
Neuropathology	48	44	.07	54	49	.1
Pediatrics	250	5,028	8.3	253	5,301	8.2
Pediatric allergy	57	137	.2	25	64	.1
Pediatric cardiology	52	101	.2	51	125	.2
Physical medicine and rehabilitation	67	476	.8	65	462	.7
Plastic surgery	114	392	.6	109	406	.6
Preventive medicine, general	23	139	.2	32	189	.3
Aerospace medicine	5	54	.09	3	30	.1
Occupational medicine	21	21	.03	26	72	.1
Public health	21	29	.05	18	21	(3)
Psychiatry	243	4,374	7.2	232	3,934	6.1
Child psychiatry	134	564	.9	130	542	.8
Radiology, diagnostic	[4] 263	2,666	4.4	220	2,905	4.5
Radiology, diagnostic (nuclear)				30	54	.1
Radiology, therapeutic	116	414	.7	105	396	.6
Surgery	401	7,899	13.0	352	7,968	12.5
Pediatric surgery				17	24	(3)
Thoracic surgery	106	292	.5	101	270	.4
Urology	175	1,107	1.8	162	1,052	1.6
Total	4,680	60,561	100.0	4,630	64,332	100.0

[1] Directory of Accredited Residencies 1977–78, Liaison Committee on Graduate Medical Education.
[2] Directory of Residency Training Programs Accredited by the Liaison Committee on Graduate Medical Education 1979–80.
[3] Less than 1/100 percent.
[4] Indicates categories radiology and diagnostic radiology.

Observers have noted the greater relative supply of primary care physicians in other countries, and have suggested from such comparisons that a shortage of primary care physicians exists in this country. The following Table 27. indicates that in the United Kingdom, general practitioners constitute 40 percent of the total number of physicians;

in Canada, they represent 42 percent of the total; and in West Germany and Belgium, 54 and 57 percent, respectively.

TABLE 27.—MEDICAL MANPOWER DATA FOR THE UNITED STATES AND SELECTED COUNTRIES[1]

Country	Number of general practitioners	Total number of physicians	Percent general practitioners are of total number of physicians	Physicians per 10,000 inhabitants
United States (1976)[2]	63, 496	362, 445	18	16. 8
United Kingdom (1975)	24, 500	60, 000	40	11. 1
Canada (1975)	16, 374	39, 104	42	17. 0
West Germany (1975)	64, 627	118, 726	54	19. 2
Belgium (1975)	10, 548	18, 506	57	18. 9
Netherlands (1976)	4, 937	21, 892	22	15. 9
Turkey (1975)	9, 016	21, 714	42	5. 4
Yugoslavia (1973)	12, 017	24, 247	50	11. 6

[1] Specialty designation may vary from country to country. These comparisons include data for general practitioners only in contrast to other designated specialties. It is recognized, for example, that in the United States and in possibly other countries in this table, internists and pediatricians are functioning as primary care physicians not unlike the general practitioner.

[2] The total number of physicians include active M.D.'s and D.O.'s that can be classified by specialty. General practitioners include family practitioners. Source: Goodman, Louis, "Physician Distribution and Medical Licensure in the United States," 1976, AMA, 1977; Osteopathic Medical Manpower (OMMI) Report 1977.

Source: Interim Report of the Graduate Medical Education National Advisory Committee to the Secretary, Department of Health, Education, and Welfare, April 1979, p. 39.

Several medical organizations have issued recommendations on the need for primary care physicians. In June 1973, the House of Delegates of the American Medical Association considered and adopted a recommendation that the need for more primary care physicians should be accepted as fact, even though it was difficult to determine precisely the additional numbers needed at that time. To meet the need for more primary care physicians, there should be, the House of Delegates agreed, greater numbers and proportions of medical graduates engaged in residency training in the primary care specialties, especially family practice. The House of Delegates approved at this time a recommendation that at least 50 percent of all medical graduates should enter residency training in the primary care specialties in the coming years.

In 1973, the Graduate Medical Education Committee of the Association of American Medical Colleges recommended that 50 percent of graduating medical students enter training programs in the primary care specialties.

In January 1975, the Coordinating Council on Medical Education recommended an initial national target of having 50 percent of graduating medical students choose careers as primary care specialists.

The 1978 Institute of Medical report, A Manpower Policy for Primary Health Care indicated that the paucity of relevant data did not enable its steering committee to recommend a precise percentage goal for primary care residencies, but did assert that most physicians should be primary care practitioners, because primary care includes the management of the great majority of problems presented by patients.[9] This report stated that committee members were inclined to believe that a figure significantly greater than 50 percent, perhaps in the range of 60

[9] A Monpower Policy for Primary Health Care. Institute of Medicine, National Academy of Sciences, May 1978, p. 72.

to 70 percent, should be chosen as a national goal for the percent of first-year residents in primary care fields.

> In the committee's opinion, primary care is a unique service, best provided by those trained to provide it. Primary medical care can be provided by any practicing physicians but most sensibly is provided by physicians trained in primary care residencies, rather than in other fields. And, because the committee's definition specfies that primary care could include the management of the great majority (more than 90 percent) of health problems presented to physicians, as well as the coordination of the management of referred cases, most physicians probably should receive their specialty training in primary care. However, the committee is inclined to believe that a figure significantly greater than 50 percent, perhaps in the range of 60 to 70 percent, should be chosen, now during the transition when shortages exist in the supply of primary care practitioners.[10]

The Institute of Medicine (IOM) report noted that such a goal should be considered during a transition period when shortages exist in the supply of primary care practitioners. This goal should also be considered because assignment of a medical graduate to a residency in internal medicine or pediatrics does not guarantee the making of a lifelong primary care practitioner. The resident may later decide to obtain training in a subspecialty, to change specialty fields in mid-career, or to limit the primary care portion of a practice to selected procedures or certain times. The report observed that in the years 1971–75, 15,241 doctors of medicine became certified in general internal medicine, while 6,986 certificates were awarded in internal medicine subspecialties.[11] According to the Institute of Medicine report, these figures suggest that, in many cases, graduate training in general internal medicine is an early step in preparation of a subspecialist rather than a primary care practitioner.

The Institute of Medicine, in addition, noted that training more physicians in primary care might have a desirable impact on problems associated with the geographic maldistribution of health manpower. IOM's report observed that, unlike physicians in general, family physicians are concentrated in rural areas. In 1976, 54.9 percent were located in cities with populations of 30,000 or under, and 11.1 percent practiced in cities with populations between 2,000 and 5,000.[12] According to the American Academy of Family Physicians, over 50 percent of the graduates of family practice residency programs in 1978 entered practice in communities with populations of less than 25,000, and in 1979, 48.8 percent of such graduates entered practice in communities of 25,000 or less.

b. Area health education centers

The Area Health Education Centers (AHEC) program and an authority for Health Manpower Education Initiative Awards were

---

[10] Ibid.
[11] Ibid., p. 71.
[12] Ibid., p. 52.

established in the Comprehensive Health Manpower Training Act of 1971. AHECs were intended by Congress to improve the accessibility and quality of health care in underserved areas, as well as to provide broader community-based learning experiences for students of the health sciences. The Committee observed in its 1971 report:

> Experience has shown that when a health training center is established in a given locality the range and quality of health services available to the people of the community rise. At the same time the opportunity for education and training of able young people who wish to undertake careers in health care increases. Moreover, those who take their training in such a center tend to remain in the locality to practice. While many factors affect how and where professionals practice, the places students are trained and the types of curriculums to which they are exposed during that training have an important influence.[13]

The 1970 Carnegie Commission report on Higher Education and the Nation's Health had recommended the establishment of area health education centers to improve the geographic maldistribution of health care personnel in rural and inner-city urban areas:

> In some parts of the country the distances between university health science centers are likely to be very great, as in the sparsely populated mountain states. Elsewhere, concentration of people in congested urban areas would overwhelm the facilities of even the largest health science center. In both types of areas there should be "area health education centers," which would provide facilities for patient care, often on a referral basis from surrounding areas; educational programs for house officers and, to some extent, for M.D. candidates who could rotate through an area health education center from a university health science center; clinical experience for allied health students; and continuing education programs for health manpower.
>
> These area health education centers, in essence, would be satellites of the university health science centers and would be visited on a regular basis by the faculty of the health science centers with which they were affiliated. Their educational programs would be developed and supervised by the health science faculty, and their patient care functions would rely on the expertise of the health science center personnel. The area centers in turn would provide assistance and counsel to the community and neighborhood health care facilities, including the private practitioner.[14]

The Department of Health, Education and Welfare (HEW) began funding the AHEC program late in 1972. At that time, contracts with eleven schools of medicine were signed for the development of AHECs in various parts of the country. These medical schools were located at

---

[13] U.S. House of Representatives. Committee on Interstate and Foreign Commerce, Comprehensive Health Manpower Training Act of 1971. A Report on H.R. 8626, p. 34.

[14] Higher Education and the Nation's Health: Policies for Medical and Dental Education, A Special Report and Recommendations by the Carnegie Commission on Higher Education, October 1970, p. 55–56.

the Universities of California, Illinois, Minnesota, Missouri, New Mexico, North Carolina, North Dakota, and West Virginia, as well as the Medical University of South Carolina, the University of Texas Medical Branch at Galveston, and Tufts University.

In 1976, the report of the Carnegie Council on Policy Studies in Higher Education, Progress and Problems in Medical and Dental Education found that "the formation of area health education centers has been one of the most encouraging and impressive developments under the 1971 legislation." [15] The Council report recommended expansion of the AHEC program and identified the inner city as one of the areas most in need of AHEC development.[16]

In 1975, during the consideration of legislation extending and revising the AHEC program and other Title VII health manpower training programs, the Committee also noted the absence of AHECs in inner-city areas.

> The only overall criticism the Committee feels should be directed to the AHEC program to date is that none of the eleven existing AHECs have been directed toward the health manpower problems of inner-city urban areas. The Committee expects that a significant portion of AHECs developed under the new legislation will be designed to influence geographic distribution problems of these areas.[17]

In addition, the Committee observed the need for flexibility in the development of AHECs, so that area health education centers would be able to utilize the resources of medical and other health professions schools and of surrounding communities, and at the same time, be able to meet the needs of students and to address the particular health problems of areas served by AHECs.

> The Committee has, therefore, rewritten the section of current laws which authorizes the establishment of Area Health Education Centers to require that certain structural and performance requirements be met but has not made the requirements so rigid as to preclude the development of AHECs in virtually any geographical region in the United States.[18]

In 1979, the Carnegie Council on Policy Studies issued a technical report on Area Health Education Centers: The Pioneering Years 1972–1978 by Charles E. Odegaard. The Carnegie Council had been invited by the eleven universities with Federal AHEC contracts to undertake an evaluation of their programs, and the 1979 report discusses the findings of the evaluation studies. Among other things, Odegaard found that despite varying degrees of success and failure among pioneering AHEC projects, the AHEC concept has made significant contributions to the "better distribution of health providers, both geographically and by specialty, and to the upgrading over a lifetime of service of the knowledge and skill of health practitioners", and as such has provided "a needed antidote to the imbalance in the outcomes

---

[15] Progress and Prob'ems in Medical and Dental Education, A Report of the Carnegie Council on Policy Studies in Higher Education, 1976, p. 96.
[16] Ibid., p. 108.
[17] U.S. House of Representatives. Committee on Interstate and Foreign Commerce, Health Manpower Act of 1975. A Report to Accompany H.R. 5546, p. 38.
[18] Ibid., p. 37.

of the education process that has dominated the educational scene for health professions in the post-World War II years." [19]

Today, 21 AHEC projects receive Federal assistance. Of the 21 supported, six are rural, three are urban, four are rural/urban, and eight are statewide and are a combination of rural and/or urban. The Department of Health and Human Services (HHS) estimates that a population of approximately 58 million persons is served through this program.

c. Assistance to individuals from disadvantaged backgrounds

As the Congress has considered and passed legislation providing direct Federal support for health professions education it has sought to improve the representation of minority and low-income students in health professions schools. The Congress has noted the under-representation of minority and low-income students in health professions schools and has expressed the concern that rapidly increasing costs, of health professions education would deter such students from undertaking career training in the health professions. This Committee noted in its 1971 Report on the Comprehensive Health Manpower Training Act of 1971, Public Law 92–157;

> The length of time required to prepare students for practice in the health professions, and the tuition and other educational expenses entailed, combine to make a professional education extremely costly to the student. The rising costs of both undergraduate and professional education have particularly compounded the problem in the past few years. Few students attend medical school without substantial help from their families.
>
> Because of dependence on family support, a disproportionate number of medical and dental students are drawn from families who are able to pay for expensive professional education. For example, in 1967–58, 20 percent of medical students came from families with annual incomes of $20,000 or more, although only two percent of the families of the United States had incomes in this category. Only nine percent of medical students came from families of $5,000 or less, although one-fourth of the families in America fall in this category.
>
> The student aid amendments proposed in this bill are designed to assist increasing numbers of students to undertake and complete training in the health professions and to assure that lack of financial means on the part of their families will not prevent capable young people from entering these professions.[20]

The Congress has asserted that it is in the national interest to assure that all economic levels and all racial groups are presented in health professions schools. In order to assure access to health professions education and health career opportunities, the Congress since 1963 has authorized various Federal student loan and scholarship programs for health professions students. These are discussed in detail elsewhere in this report.

---

[19] Odegaard, Charles E., Area Health Education Centers: The Pioneering Years 1972–1978, A Technical Report for the Carnegie Council on Policy Studies in Higher Education, 1979, p. 107.

[20] U.S. House of Representatives. Committee on Interstate and Foreign Commerce, Comprehensive Health Manpower Training Act of 1971. A Report to Accompany H.R. 8629. H. Rept. No. 92–258. p. 35.

In addition, the Congress has observed that unequal representation of minority students in health professions schools could be explained not only by the high costs of education, but also by the lack of effective counseling to encourage and assist minority and low-income students to enter the health professions. In the Comprehensive Health Manpower Training Act of 1971, Congress authorized Health Manpower Education Initiative Awards. This program of project grants was intended, in part, to (1) encourage and assist increased numbers of individuals from minority or low-income groups to undertake training in, and successfully complete, professional courses of study in health professions schools, and (2) to encourage the enrollment of students likely to practice in rural or other areas having a shortage of such personnel.

The Cogress noted in 1971 that students from low-income backgrounds are frequently from physician-shortage areas in rural or urban America, and that physician recruitment for rural and other shortage areas would be greatly enhanced if more young people who come from rural or urban physician-shortage areas were encouraged to enter the medical profession.

In 1976, with the enactment of Public Law 94–484, Congress amended this program and replaced it with a new but similar authority for grants and contracts to health professions schools and other health or educational entities to assist students from disadvantaged backgrounds in gaining admission into and completing health professions training. As with the earlier authority, the new program does not contain specific authority to pay stipends for students. Rather, the focus continues to be on identifying individuals, facilitating their entry into schools, providing counseling, providing preliminary education as needed, and publicizing existing sources of financial aid. In fiscal year 1978, $15 million was awarded for 142 projects for this program. For fiscal year 1979, $19 million was awarded for 151 projects.

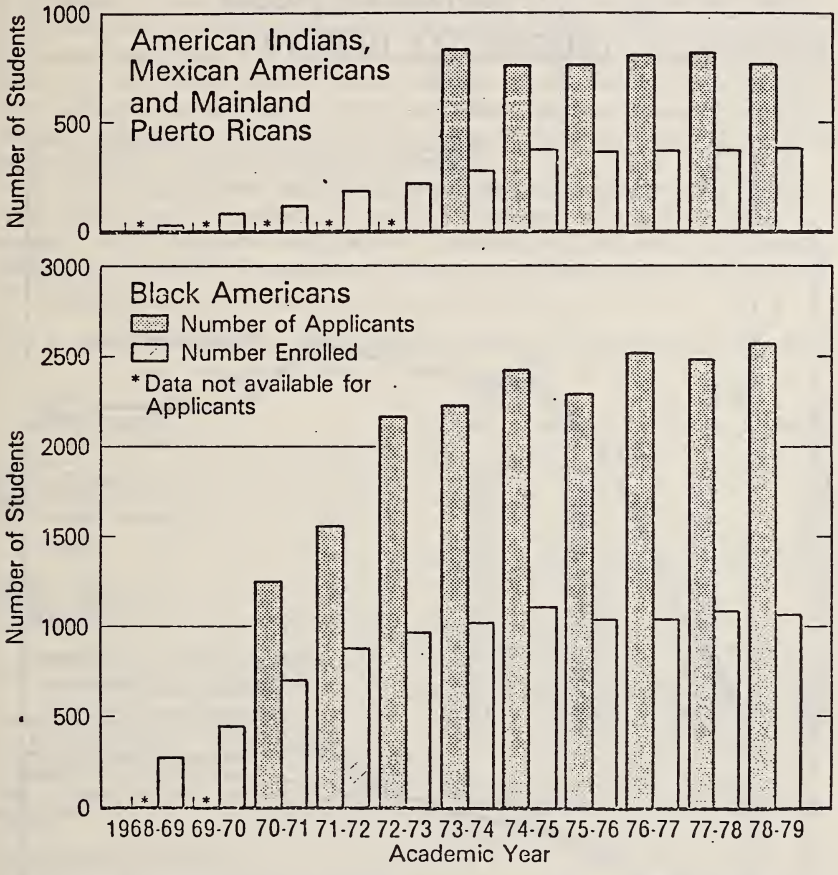
Minorities remain under-represented in health professions schools. The following Chart two illustrates changes in the number of minorities applying to medical schools and those actually enrolled in first-year classes. In 1968–69, there were 266 blacks enrolled in first-year medical school classes. By 1974–75, black enrollment in first year classes had increased to 1,106. Since then, the number of blacks enrolled in first-year classes has decreased, with 1,061 enrolled in first-year classes for 1978–79.

The number of American Indians, Mexican Americans, and Mainland Puerto Ricans enrolled in first-year medical school classes increased from 26 in 1968–69 to 367 in 1974–75. Since that time, the number of these minorities enrolled in first-year classes has remained relatively constant. In 1978–79, 382 such persons were enrolled in first-year classes.

In 1978–79, 2,564 blacks applied for admission to medical schools. While this total represents the largest number of black applicants since 1968–1969, this number has not changed significantly during the last three academic years. For other minority applicants, the total has fluctuated between 751 and 822 since the academic year 1973–74.

CHART TWO

MINORITY APPLICANTS AND ENROLLEES IN FIRST YEAR MEDICAL SCHOOL CLASSES, 1968-69 TO 1978-79



Source: Medical Education: Institutions, Characteristics and Programs, Association of American Medical Colleges, August 1979.

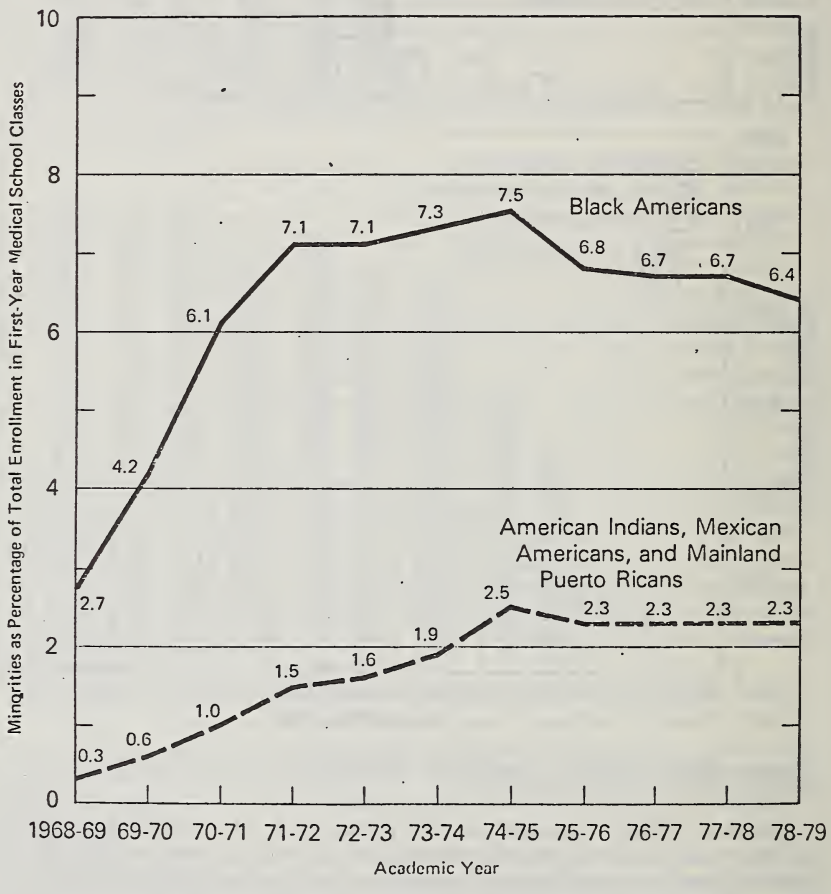
Chart 3, details changes in the proportion of minorities enrolled in first-year medical school classes for 1968–69 through 1978–79. In 1968–69, blacks constituted 2.7 percent of students enrolled in first-year classes, and other minorities—American Indians, Mexican Americans, and Mainland Puerto Ricans—constituted 0.3 percent of total first-year enrollments. Minority first-year enrollment as a percent of total first-year enrollments increased annually through the academic year 1974–75. In that year, blacks represented 7.5 percent of total first-year enrollments, and other minorities 2.5 percent. Since that year, the pro-

62-655 O - 80 - 6

portion of both these groups entering medical schools has declined. For the academic year 1978–79, blacks enrolled in first-year medical school classes amounted to 6.4 of total enrollments, and other minorities represented 2.3 of the total.

CHART THREE

MINORITIES ENTERING MEDICAL SCHOOLS, 1968-69 TO 1978-79



Recent trends in parental income of students in medical schools show that, between the academic year 1970–71 and 1977–78, the median parental income of medical school students increased from $14,627 to

$25,000. In addition, the following Table twenty-eight provides data on the changes in the socio-economic background of students seeking admission to medical schools.

For these purposes, the socio-economic background of students was determined by indications of fathers' occupations. In 1973–74, 61.3 percent of those students applying to medical schools indicated their fathers' occupation as either physician, other health profession, other profession, or owner, manager, administrator. As a proportion of students accepted to medical schools, students indicating these several professional categories for fathers' occupations amounted to 64.3 of the total. On the other hand, those students whose fathers' occupations were indicated as clerical or sales, craftsman, skilled worker, unskilled worker or farmer constituted 27.4 percent of those applying to medical schools and 25.1 percent of those accepted.

By 1977–78, students indicating a professional category for fathers' occupation had increased to nearly 70 percent of total students accepted, while students with fathers' occupations indicated as clerical, skilled and unskilled worker, or farmer had decreased to 19.2 percent of the total.

TABLE 28.—FATHER'S OCCUPATION OF MEDICAL SCHOOL APPLICANTS AND ACCEPTEES 1973–74 AND 1977–78

Father's occupation	1973–74		1977–78	
	Applied	Accepted	Applied	Accepted
Physician	12.0	13.4	12.6	14.6
Other health profession	4.2	4.4	4.0	4.3
Other profession	25.0	27.6	24.1	25.7
Owner, manager, administrator	20.1	18.9	25.3	25.3
Subtotal	61.3	64.3	66.0	69.9
Clerical or sales	7.6	7.5	5.1	4.7
Craftsman, skilled worker	11.5	9.9	9.6	8.0
Unskilled worker	5.2	4.8	4.5	4.1
Farmer, farmworker	3.1	2.9	2.5	2.4
Subtotal	27.4	25.1	21.7	19.2
Other	11.2	10.5	12.2	11.0
Total percent [1]	99.9	99.9	99.9	100.1
Number responding	34,523	13,019	38,946	15,451

[1] Differ from 100 due to rounding.

Source: Medical Education: Institutions, Characteristics and Programs, Association of American Medical Colleges, August 1979.

d. Financial distress

In the Comprehensive Health Manpower Training Act of 1971, Congress established a separate authority for financial distress grants to provide emergency financial assistance to schools experiencing acute financial difficulties; to assist schools in meeting accreditation requirements; and to provide assistance for schools to carry out appropriate operational, managerial, or financial reforms. Since 1972, over 30 health professions schools have been awarded assistance under this authority. Tables 29 and 30 summarize recent experience under this program.

TABLE 29.—NUMBER OF FINANCIAL DISTRESS GRANTS[1] AWARDED TO HEALTH PROFESSIONS SCHOOLS, BY TYPE OF SCHOOL, FISCAL YEARS 1972–79

Fiscal year	Total	Type of school						
		Medicine	Osteopathy	Dentistry	Optometry	Pharmacy	Podiatry	Veterinary medicine
Total	89	29	3	25	7	8	10	7
1972	18	6	1	4	2	2	2	1
1973	18	7	1	4	2	2	1	1
1974	20	8	0	5	2	1	2	2
1975[2]	14	4	1	5	0	1	2	1
1976[2]	12	3	0	5	1	1	1	1
1977[2]	7	1	0	2	0	1	2	1

[1] Since 1978, financial distress grants have been funded under a special project grant. See table III–9 for 1978 and 1979 data.
[2] Does not include financial distress support to 3 schools under the program: grants to assist District of Columbia Medical and dental schools: Fiscal year 1975, $7,500,000; fiscal year 1976, $8,817,000; fiscal year 1977, $8,857,000.

Source: Trends in BHM Program Statistics, Grants, Awards, Loans fiscal year 1957–77, DHEW, HRA, BHM.

TABLE 30.—AMOUNT OF FUNDS AWARDED TO HEALTH PROFESSIONS SCHOOLS FOR FINANCIAL DISTRESS GRANTS,[1] BY TYPE OF SCHOOL, FISCAL YEARS 1972–77

[In thousands of dollars]

Fiscal year	Total	Type of school						
		Medicine	Osteopathy	Dentistry	Optometry	Pharmacy	Podiatry	Veterinary medicine
Total	46,774	25,229	768	13,200	896	2,033	2,621	2,026
1972	11,151	6,610	350	2,241	270	1,150	135	386
1973	9,210	5,767	340	1,933	324	155	392	298
1974	11,948	7,447	0	2,692	193	145	600	871
1975[2]	5,000	2,055	68	2,022	0	172	546	137
1976[2]	5,000	1,838	0	2,399	109	241	282	131
1977[2]	4,465	1,512	0	1,913	0	170	666	203

[1] Since 1978, financial distress grants have been funded under a special project grant. See table III–9 for 1978 and 1979 data.
[2] Does not include financial distress support to 3 schools under the program: Grants to assist District of Columbia medical and dental schools: Fiscal year 1975, $7,500,000; fiscal year 1976, $8,817,000; fiscal year 1977, $8,857,000.

Note: Detail may not total due to rounding.

Source: Trends in BHM Program Statistics, Grants, Awards, Loans, Fiscal year 1957–77, DHEW, HRA, BHM.

4. Proposed legislation

Over the past two decades, project grants and contracts have proved to be an effective way to address specific health manpower problems. Awarded only to schools and other entities that agree to undertake projects directed to one or more problem areas, these grants are an efficient use of limited funds.

The Committee believes that project grants can continue to contribute to the resolution of major health manpower problems in the coming three years. In particular, the Committee proposal extends, with revisions, grant and contract programs for primary care, Area Health Education Centers, health professions students from disadvantaged backgrounds, financial distress, physicians' assistants and expanded function dental auxiliaries, and a variety of other purposes.

a. Primary care

A variety of factors, among them the emphasis of medical schools on biomedical research and the failure of third party health insurance to support adequately ambulatory services, contribute to the shortage of post-graduate physician training positions in the primary care specialties. In response, the Committee proposal continues and expands the three existing programs designed to encourage and support the training of primary care physicians.

(i) In 1976, the Committee established a program to encourage schools of medicine and osteopathy to establish family medicine departments equivalent to other academic departments. Such departments provide the institutional base for professionals concerned with primary care similar to those enjoyed by the various medical specialists. Studies indicate that students from schools with departments of family medicine enter residency training in that specialty in greater numbers than graduates of similar institutions without such departments.

In fiscal year 1980, the first year in which funds have been appropriated for this program, more than 60 schools have applied for such grants; the Department anticipates that only 35 awards, however, will be made due to limited funds. In order to support the development of strong departments of family medicine at more schools, the Committee proposal authorizes $15 million, $20 million, and $25 million for this program for fiscal years 1981, 1982 and 1983, respectively.

(ii) Over the years, a number of studies and reports have indicated that a major barrier to the increased training of primary care physicians is the third party reimbursement system as it relates to ambulatory care residency training.

The lack of adequate third-party funds inevitably leads to deficits in the budgets of family medicine training programs and dissuades hospital and other institutional administrators from initiating or expanding family medicine training programs.

The Committee is impressed that the family medicine project grant program has contributed to the increase in the number of young physicians trained in family medicine since 1971. In 1979–80, for example, 95 family medicine training programs received assistance from this program.

In order to assist the development of additional family medicine training programs and to assist in the expansion of existing programs, the Committee proposal provides authorizations of $50 million, $75 million and $80 million for the fiscal years 1981, 1982, and 1983, respectively.

The Committee proposal also requires the Secretary to conduct a study to determine the most effective and efficient method of supporting family medicine, primary internal medicine, and primary pediatrics training programs. Since the primary care grant programs represent long term operational, rather than initial development, assistance the Committee is interested in considering alternatives to the current grant mechanism which requires training programs to apply for a renewal of support every three to five years. The study should review alternative funding sources for primary care training, including revised

Medicare-Medicaid payments and formula allocation of grant funds. In selecting individuals to undertake this study the Committee anticipates that the Secretary will include persons with expertise in primary care medical education and reimbursement mechanisms for health services.

Finally, the Committee notes that it specifically rejected a proposal to delete the requirement that 10% of the funds appropriated under the Grant Program for Family Medicine and General Practice of Dentistry be set aside to support training in the general practice of dentistry.

(iii) General internists and general pediatricans can contribute to an alleviation of the need for additional physicians specifically trained to provide primary care. Recent studies have indicated that less than 10 percent of overall training time in traditional internal medicine residency programs is devoted to primary, ambulatory care. Emphasis on this service, which makes up the great bulk of medical practice, is the major feature of general internal medicine and general pediatrics training programs.

Since training programs specifically targeted to general internal medicine and general pediatrics face the same financial problems as those of family medicine, a similar program of project grants is appropriate. The Committee proposal thus extends the existing project grant program by providing authorizations of $23 million, $30 million and $32 million for fiscal years 1981, 1982, and 1983, respectively. Additionally, the Committee proposal expands the scope of the general internal medicine and general pediatrics authority to include programs for training of physicians who will teach in such programs. The Committee anticipates that, under this new authority, internists and pediatricians from academia as well as practice may be recruited and trained to augment the supply of faculty in these primary care areas.

b. Area health education centers

Area Health Education Centers (AHEC) programs are cooperative efforts between medical and osteopathic schools and community groups to decentralize medical and other health professions education. These programs have proved to be an effective approach to link health educational, service, and planning institutions into cooperative systems for manpower development. They have provided an effective means of bridging the gap between community and academic institutions. The program has enabled health science centers, community hospitals, and other local educational institutions to coordinate and integrate their resources and training programs to provide training which addresses the identified manpower needs of particular communities. In the process, AHECs have improved the accessibility and availability of health services in areas of need and have served to attract and retain health professionals in shortage areas. Since 1974, the Department has assisted the development of 23 AHECs programs throughout the nation.

The Committee is impressed that AHECS can improve the distribution of physicians and other health professionals in a positive and voluntary manner. Unfortunately, limited funds have been avail-

able for the AHEC program in recent years and only 12 new AHEC projects have been initiated since 1976. In 1979, the last year in which funds were available for new AHECs, more than 7 schools expressed an interest in developing AHEC projects while funds were available to be awarded to only three.

The Committee proposal extends the existing AHEC program through fiscal year 1983. Slightly increased authorizations, $28 million and $30 million, are provided for fiscal years 1982 and 1983, in the anticipation that a new group of AHECs, perhaps as many as 10, may be initiated in those years.

The Committee also notes that it is impressed by the commitment of a number of states, especially North Carolina, South Carolina, Ohio and California, to establish statewide AHEC's; the Committee intends for additional statewide projects to be initiated wherever possible.

The Committee proposal also provides that continued Federal support, to a maximum of 10 percent of the total AHEC appropriation in any fiscal year, may be provided to AHEC programs which have previously received initial development support. In particular, the Committee anticipates that the Department will support specific projects proposed by AHEC programs first initiated in 1972 which promise to improve the distribution of health professionals in their areas. Projects designed to assist the National Health Service Corps by providing preceptorships in shortage areas would be an example of a particularly appropriate type of project. The Committee does not intend for any AHEC program otherwise supported under the existing program authority to receive funds under this new provision.

c. Educational assistance to individuals from disadvantaged backgrounds

While the number of students from disadvantaged backgrounds entering the health professions increased during the early 70's, the number and percentage of such students has decreased in the past four years. In response to the continuing need for support for programs to encourage students from disadvantaged backgrounds to attend health professions schools, the Committee proposal revises and extends the current authority for grants and contracts for programs which provide assistance to such individuals.

The Committee proposal addresses three factors which many believe contribute to the current limitation on the number of students from disadvantaged backgrounds in health professions schools.

(i) One impediment to increased enrollment of disadvantaged students is a limited pool of qualified applicants. Many students from disadvantaged backgrounds do not receive adequate preprofessional education to permit them to compete successfully in the application process. The Committee proposal thus authorizes support for projects to strengthen the preprofessional curricula in secondary schools and colleges and to establish joint efforts between health professions and baccalaureate degree schools.

(ii) A second factor which may discourage individuals from disadvantaged backgrounds from entering careers in the health professions is the high cost of health professions training. As previously

described, the Committee proposal provides increased assistance to such students by expanding authorizations for the Exceptional Financial Need scholarship program. The Committee also intends that the educational assistance program contribute in this area by publicizing existing sources of financial aid and by developing work-study opportunities in health services agencies. The Committee notes that work-study opportunities may be especially appropriate for students in schools of nursing. However, it is not this Committee's intention that funds appropriated under this authority be used to provide wages under work-study programs.

(iii) Finally, surveys indicate that a higher percentage of students from disadvantaged backgrounds fail to complete health professions training than students from other backgrounds. To address this problem, the Committee proposal provides assistance for projects to provide counseling and other necessary services for disadvantaged individuals to successfully complete their health professions education.

The Committee proposal provides that not less than 80% of the funds should be obligated for grants and contracts to health professions and other educational institutions. The Committee hopes that this targeting of funds will provide better program management and increase the number of students from disadvantaged backgrounds who enroll in health professions institutions in future years.

d. Financial distress

The authority for the Secretary to make grants to health professions schools in financial distress is continued as a separate provision of the Public Health Service Act. As is currently the case, financial distress funds are to be available to any health professions school in serious financial distress to assist in meeting the costs of operation and to carry out appropriate operational—managerial—and financial reforms. However, the Committee intent is to give priority for financial distress grant awards to those minority health institutions which have been in severe financial distress over the past few years.

Since four schools—Meharry Medical and Dental Schools, Tuskegee School of Veterinary Medicine, and Xavier University School of Pharmacy—have made substantial contributions toward increasing the number of minorities in the health professions even while experiencing severe financial distress, the Committee believes that they warrant preferential Federal attention.

In fiscal year 1980, in addition to the four schools just mentioned, three institutions with less severe problems received direct financial distress assistance and conducted management studies designed to reduce their financial difficulties. These seven schools are projected to have continuing problems in financing their educational programs. The Department estimates that approximately ten schools, including those receiving aid in fiscal year 1980, are expected to experience financial difficulty in future years.

The Committee has provided authorizations of appropriations of $20 million for each of the next three fiscal years—to remain available until expended—to provide such financial distress assistance. In those unusual circumstances where previous or past capital construction debts threaten the viability of an institution's operation, the Secretary

may use these funds to meet such liabilities, although the Committee expects such use of funds to be severely limited.

e. Other projects

In addition to these four major areas, the Committee extends, with some revisions, existing authorities for a number of other projects. In all of these areas, the Committee finds that limited amounts of funds have, over the past four years, efficiently addressed significant health manpower training problems.

(i) Since 1971, the Committee has supported the training and utilization of physician extenders. In 1977, for instance, the Committee reported the Rural Health Clinic Act, which provides for Medicare and Medicaid payments to physician assistant—and nurse practitioner—operated clinics in rural areas.

After reviewing the operation of physician assistant and dental auxilliary training programs since 1976, the Committee notes that evidence continues to show that significant numbers of physician assistants enter practice in rural areas. These professionals help increase the productivity of primary care physicians and thus increase the supply of needed medical services in these areas.

The Committee proposal makes no changes in the physician assistant and dental auxiliary authority and extends it for three years at authorizations of $14 million, $15 million, and $16 million for fiscal years 1981, 1982, and 1983, respectively. However, the Committee encourages these programs to seek to develop a funding base other than Federal grants under this authority.

(ii) The Committee proposal extends the authority for grants for two year medical schools to convert to full-fledged schools of medicine. In particular, the Committee notes that the medical education program at Morehouse University in Atlanta is currently in the process of becoming a four year school of medicine.

(iii) Finally, the Committee proposal extends with minor revision, existing authority to make grants to and enter into contracts with health professions institutions or any public or nonprofit private entity to support a variety of projects and programs to improve the education of health professionals, including projects in the areas of nutrition, geriatrics, clinical psychology, and curriculum development.

Two minor revisions of this authority are contained in the Committee proposal. The first adds schools of dentistry to the list of health professions institutions in which curriculum development projects can be supported. This change was made in recognition of innovative curriculum development activities which have been initiated by several schools of dentistry.

The second change adds programs for the training of health professionals in the diagnosis, treatment, and prevention of diabetes and other severe chronic diseases and their complications to the list of projects eligible for funding. This new authority would enable the Secretary to support inter-disciplinary training programs relating to diabetes or other severe chronic diseases and their complications in order to upgrade the knowledge of health professionals involved in the care of patients with these diseases.

PART E—PUBLIC HEALTH PERSONNEL

1. Background

The original mission of schools of public health was primarily to prepare personnel for State and county health departments whose principal professional concern was communicable disease control. The increasing demand for health services and the growing awareness of environmental health hazards have revised this original mission significantly. The Committee heard testimony, at its hearings earlier this year, underscoring the importance of this mission. As one witness stressed:

> Public health deals with the protection and improvement of community health by organized community effort. Public health activities are essentially a public or government responsibility. The services of public health agencies are not reimbursable on a fee-for-service basis as are personal health services. Rather than treating the symptoms of disease in one person, public health is concerned with discovering how a disease occurs, in halting its spread and in organizing programs for those who have been or may be effected by it in a community, a State or a Nation. The goal in theory and in practice is to discover the source of ill health and to reduce or eliminate it at the earliest point. As a public responsibility such preventive activities have been largely supported by public funds.
>
> Public health measures have been successful in controlling communicable diseases as a major cause of death in the United States. While these measures should continue to prevent a resurgence, today the major public health problems in this country involve the causes and control of chronic diseases such as cancer and heart disease; the control or elimination of environmental health hazards; and the provision of equal access to qualify health care at reasonable costs.[1]

Advances in the role of public health have placed new demands on the institutions which educate and train such professionals. These ininstitutions must meet the challenge of preparing public health professionals for the increasingly varied and challenging roles they will be asked to play.

The institutions which train public health personnel have a role beyond their training function. Many bring together in a single location a multidisciplinary team representing several dimensions of the health services professions. Many serve as a resource for public, private, and governmental agencies for conducting research into, and providing expert advice on a multiplicity of health-related problems. Many schools of public health also conduct applied biomedical research.

Within the past decade, a considerable number of graduate programs in health and hospital administration have developed outside the more traditional setting of schools of public health. These programs are based in a variety of settings: schools of allied health; schools of medi-

[1] Testimony presented to the Committee by the Association of Schools of Public Health on March 24, 1980.

cine; and graduate schools of business administration, management, public administration, and public affairs. Many have developed as cooperative efforts between two or more schools within a university, reflecting the need to bring together disciplines such as health and management.

Federal recognition of the value of public health professionals is not new. Enactment, in, 1956 of authority for public health traineeships to encourage development of experienced public health professionals was one of the first Federal health manpower training programs. This was followed in 1958 by authority for institutional formula grants to schools of public health, and in 1960, by project grants for graduate or specialized public health training.

These three authorities—formula grants to schools of public health, traineeships, and special project grants—were extended by various Acts, through fiscal year 1977.

The Health Professions Educational Assistance Act of 1976 repealed the existing authorities for public health training and replaced them with new authorities, effective in fiscal years 1978 through 1980, as follows:

(1) Grants to schools of public health for traineeships for students studying (a) biostatistics or epidemiology; (b) health administration, health planning, or health policy analysis and planning; (c) environmental or occupational health; or (d) dietetics or nutrition;

(2) Grants to educational entities other than schools of public health which offer accredited programs in health administration, hospital administration, or health policy analysis and grants for traineeships for students enrolled in such a program;

(3) Formula grants to educational entities other than schools of public health to support graduate educational programs in health administration, hospital administration, and health planning; and

(4) Special project grants to schools of public health and other educational entities to develop new programs or expand existing ones in (a) biostatistics or epidemiology; (b) health administration, health planning, or health policy analysis or planning; (c) environmental or occupational health, or (d) dietetics and nutrition.

Although the 1976 legislation repealed the formula grant authority for schools of public health, it made such schools eligible for capitation grants under section 770 of the PHS Act, start-up grants under section 788(a), and financial distress grants under section 788(b). Also, schools of public health and other entities providing graduate or specialized training in public health became eligible for special project assistance under the health professions special project authorities in sections 788(c) (interdisciplinary team training) and 788(d) (curriculum development).

The Health Professions Education Amendments of 1977 broadened eligibility for the traineeship program and added "preventive medicine or dentistry" to the areas of study covered by the program.

The following tables show the recent funding history of the four separate grant authorities for public health and health administration programs.

TABLE 31.—PUBLIC HEALTH TRAINEESHIPS

Fiscal years	Amount author. (millions)	Amount approp. (millions)	Amount awarded (millions) Total	Cont.	New	Formula	Number of awards Total	Cont.	New	Formula	Trainees (long term)
1965–77	$138.6	$111.0	$102.8	INA	INA	INA	INA	INA	INA	INA	INA
1978	7.5	7.0	7.0	0.5	--------	$6.5	34	14	--------	20	2,168
1979	9.0	6.9	6.9	.7	--------	6.2	35	14	--------	21	2.228
1980	10.0	7.0	7.0	.1	0.3	6.6	32	1	10	21	2,241
1981	(1)	7.0	7.0	.4	--------	6.6	32	10	--------	2	2.241

[1] Expires.

Note: The average award per grant in fiscal year 1980 is $333,333 benefiting 107 students.

Source: Department of Health and Human Services, Health Resources Administation, Bureau of Health Manpower

TABLE 32.—HEALTH ADMINISTRATION TRAINEESHIPS

Fiscal year	Amount authorized (millions)	Amount appropriated (millions)	Amount awarded formula (millions)	Number of awards formula	Average amount of award	Trainees
1978	$2.5	$1.5	$1.5	21	$71,500	424
1979	2.5	2.0	2.0	25	80,900	565
1980	2.5	2.0	2.0	26	76,923	565
1981	(1)	2.0	2.0	28	71,424	565

[1] Expires.

Note: The average award per grant in fiscal year 1980 is $76,900 benefiting 26 students.

Source: Department of Health and Human Services, Health Resources Administration, Bureau of Health Manpower.

TABLE 33.—GRADUATE PROGRAMS FOR HEALTH ADMINISTRATION

Fiscal year	Amount authorized (millions)	Amount appropriated (millions)	Amount awarded formula (millions)	Number of awards formula	Average amount of award	Students benefited
1964/1977	$108.5	$65.4	$62.0	22	INA	INA
1978	3.3	3.0	3.0	22	$137,000	[1] $1,500
1979	3.5	3.0	3.0	24	125,000	[1] 1,800
1980	3.8	3.0	3.0	26	115,400	[1] 1,950
1981	(2)	3.0	3.0	28	107,100	[1] 2,100

[1] Estimated.
[2] Expires.

Source: Department of Health and Human Services, Health Resources Administration, Bureau of Health Manpower.

Note: The average award per grant in fiscal year 1980 is $115,400.

TABLE 34.—PUBLIC HEALTH SPECIAL PROJECT GRANTS

Fiscal year	Amount author. (millions)	Amount approp. (millions)	Amount awarded (millions) Total	Cont.	New	Number of awards Total	Cont.	New	Avg. amt. of award	Students benefited
1978	$5.0	$5	$5.0	$1.8	$3.2	90	32	58	$55,600	$2,525
1979	5.5	5	4.9	4.2	.7	109	94	15	45,900	2,525
1980	6.0	5	5.0	4.2	.8	97	82	15	51,500	2,500
1981	(1)	5	5.0	1.6	3.4	93	31	62	53,800	2,500

[1] Expires.

Note: The average award per grant in fiscal year 1980 is $51,500.

Source: Department of Health and Human Services, Health Resources Administration, Bureau of Health Manpower.

2. Need

When the 1956 legislation was enacted to authorize the first assistance for public health training, there were eleven schools of public health with a total enrollment of just over 1,000. At the present time, there are 21 accredited schools of public health in the United States with a combined enrollment of over 7,000 students and a faculty in excess of 1,700.

According to testimony presented to the Committee this year:

> Graduates of the Schools of Public Health work primarily in the public sector in the areas of health promotion and disease prevention. They represent the basic resource pool from which Federal, State, and local health and environmental agencies draw their manpower needs. Graduates also work and teach in university settings. Industry relies heavily on the Schools to train their employees involved in industrial hygiene, occupational safety and health, environmental toxicology, among others. The breakdown is as follows: 50 percent of graduates in a single given year go into Federal, State or local Government service, 34 percent work for either nonprofit community health agencies or universities and four percent work for industry.
>
> ASPH data shows that the Schools no longer primarily train professionals for state and local government agencies. In response to a demand for new types of health workers and a broader concept of public health, the Schools have made major efforts to train students in health administration and environmental health, now the two most frequently chosen areas of specialization. Health administration attracted 1,069 students in 1977–78, or 16.6 percent of the total. With health planning and policy studies counted in, that total would be even higher. Hospital administration, treated as a separate discipline, drew an additional 299 students (4.6 percent) in 1977–78. With biomedical laboratory sciences reported separately, environmental health narrowly displaced epidemiology as the second most frequently chosen specialty. Biostatistics ranked third with 440 students in 1977–78 (6.8 percent), while health education was fourth with 421 students (6.5 percent) and nutrition fifth with 382 students (5.9 percent).[2]

Testimony also showed that, although there is a lack of adequate data on public health manpower, there are definite shortages of certain specialized disciplines such as epidemiology, biostatistics, occupational and environmental health, and health service administration. Two HEW studies, a December 1979 report to Congress on Community and Public Health Personnel and the July 1979 Surgeon General's report, Healthy People, were cited as evidence that "the demand for the types of health manpower trained by Schools of Public Health will increase as a result of current and future legislative and administrative initiatives in the fields of disease prevention and health promotion (not to

[2] Testimony presented to the Committee by the Association of Schools of Public Health on March 24, 1980.

mention cost containment and improved management of health services delivery.)"

The Committee also heard testimony this year on the importance of the health administrator to the delivery of quality health service on an equitable and cost-effective basis. Witnesses testified that "management competence in health services is grossly uneven and the problem is growing." It was noted that there are not enough appropriately-trained administrators. Also, serious management shortages exist in HMO's, emergency medical systems, nursing homes, home health agencies, community centers, and rural and urban general hospitals.

Testimony before the Committee, also noted needs and shortages in the areas of disease prevention and health promotion. The Surgeon General's report, Healthy People, was cited concerning future shortages in the field of preventive medicine, as well as an insufficient emphasis on prevention in the training of physicians. The December 1979 report to Congress on Community and Public Health Personnel, recommended the following action by the Federal Government:

> Encourage and support the development of capabilities to provide training in health promotion, disease prevention, and other public health content in the curriculum of schools of medicine, osteopathy, dentistry, optometry, pharmacy, podiatry, veterinary medicine, and in schools offering preparation in the allied health programs * * *.

Other evidence of the need for increased support for preventive health professional training presented to the Committee at its hearings this year included statements that:

> (1) Only 88 of the Nation's 122 medical schools, have a department of preventive medicine or its equivalent. A number of these are threatened with closure due to shrinking budgets;
>
> (2) Federal support for special projects in preventive medicine within medical schools has dropped, from $1.1 million in fiscal year 1979 to zero in fiscal year 1980;
>
> (3) Less than 1.5 percent of the total undergraduate medical curriculum is devoted to prevention, in contrast to the four percent recommended by the Association of American Medical Colleges;
>
> (4) Most of the 48 active accredited residency programs in preventive medicine have only a few funded positions available. For 1978–79, the mean was 4.3 funded positions per program;
>
> (5) Although it has been estimated that 160 graduates a year in preventive medicine are required to meet needs in the field, currently only 70 complete training annually; and
>
> (6) Federal support for residency training has also declined in recent years from $1.2 million in 1973 to $100,000 a year in 1978 and 1979. In fiscal year 1980 approximately $275,000 will be made available for this purpose, according to Administration plans.[3]

[3] Testimony presented to the Committee by the American College of Preventive Medicine on Mar. 24, 1980.

3. Proposed legislation

H.R. 7203, as reported from the Committee on Interstate and Foreign Commerce, would: (1) revise, extend, and recodify existing program authority for support of Public Health and Health Administration institutions and personnel; and (2) provide new authority for program support for departments of preventive or community medicine or dentistry, traning in preventive medicine, and faculty and curricula development in Health Administration.

The Committee concurs in the recent report of the Department of Health, Education and Welfare concerning public health personnel in which the Department concluded:

> The scope of public health continues to expand as broader interpretation of public responsibilities for health, greater public participation, and demands for accountability in health matters increase. A significant proportion of the core workforce of about 150,000 individuals enters public health at midcareer from related health occupations. Most tend to specialize by working with a specific population group or health problem, or by working within a particular setting or discipline. About 25 percent of this core group now has graduate training in public health. As much as half of the workforce may require short-term training in specific areas, preferably to be acquired without leaving the job for an extended period, in order to keep abreast of the field and assure continuing competency. In addition, there are indications that educational programs may be deficient in preparing students to deal with the significant public health problems of minorities and the disadvantaged.

The Department, in that same report, recommended:

> Federal support of public health training should be continued, with modifications to make it more flexible and responsive to specific national requirements. New initiatives to improve opportunities for minorities and to increase awareness of all personnel to minority health problems are needed. Continuing competency training is needed to equip the current workforce to carry out Federal initiatives in public health. Increased efforts to obtain and analyze public health manpower data are indicated.

The Committee proposal addresses the recommendations of the Department by incorporating specific program authority designed to insure that the most responsive actions possible to meet existing public health needs will be taken.

The Committee proposal would extend the current program of institutional support (capitation) for schools of public health without significant change. The Committee is aware that the continued need for additional graduates from schools of public health is well documented, and believes that the anticipated income levels of such health professions is such that continued Federal basic institutional support is both warranted and necessary.

The Committee proposal would also extend programs of support for public health traineeships, special projects for accredited schools of public health, graduate programs in health administration, and health administration traineeships through fiscal year 1983 with minor modifications. The Committee has noted with pleasure the effect of these programs and expects, with the modifications it proposes, continued progress toward the goal of an adequate supply of well trained professionals.

In addition, the Committee proposal would authorize program support in several new areas of endeavor designed, in each case, to provide highly qualified public health personnel. The Committee proposal would authorize the Secretary to make awards for the establishment, operation, and administration of centers to provide intensive, short-term advanced training to individuals with demonstrated expertise in health policy and management in (i) health systems management, (ii) health policy, planning, and regulation, (iii) environmental policy and management, (iv) financial management and strategy in health care, (v) management of collaboration between health care entities, (vi) management of small health care entities in inner cities and rural areas, and (vii) similar matters to increase the capabilities of such individuals in carrying out their responsbilties. This special program for midcareer training and education is designed to provide advanced training for individuals who have already demonstrated expertise in their respective fields, and is therefore intended to be different from fairly wide-spread current retraining efforts to upgrade narrowly defined skills of health workers generally. The training and education provided by the proposed centers should be designed to have an immediate and positive impact on how such individuals view their responsibilities and on the kind of decisions to make.

Of necessity, the midcareer training and education programs should be brief, usually ranging from two to six weeks in duration, because of the inability of such individuals to be away from their duties for longer periods of time. Brevity, however, should not mean superficiality or generality in the coverage of subject matter.

Among other things, midcareer training centers should emphasize the need to understand and use advanced techniques of analytic and managerial sciences in health policy, planning, and administration. It should be a primary concern of the proposed centers to encourage the use of this approach for decisions that impinge upon such elements of the health sector as availability, quality and cost of medical care, the delivery of health services, identification and control of environmental hazards, and the promotion of disease prevention and health promotion.

It should be noted that, under Federal contract and grants over the past several years, this kind of midcareer training and education has been designed and tested with highly successful results. More than 1,000 health policy makers, managers, regulators and planners from 48 states and the District of Columbia have participated in such programs. These Federally-sponsored experimental programs have been strikingly effective in terms of immediate and positive impact on the health system, according to participants themselves and the organiza-

tions in which they serve, among others. The purpose of the proposed midcareer training and education authority is to strengthen and expand such experimental programs.

Finally, new authority is provided for departments of preventive or community medicine or dentistry and faculty and curricula development projects in health administration. The first authority would provide grants to schools of medicine, dentistry, and osteopathy to establish, maintain, and improve academic units in preventive or community medicine or dentistry; to improve instruction in such area; to support joint programs between other clinical specialties and preventive or community medicine or dentistry; and to train teachers and researchers in preventive, community, or occupational medicine or dentistry. Additional authority is provided to plan, develop, expand, and provide financial assistance to trainees in residency training programs in preventive medicine. Under the new health administration program authorities, grants may be made to meet the costs of curriculum development and to establish and operate faculty development programs. Each of these authorities has been proposed by the Committee as a mechanism to help alleviate existing shortages in the critical areas of public health and health administration.

PART F—ENVIRONMENTAL AND OCCUPATIONAL HEALTH PERSONNEL NEEDS—STUDY

The Committee has called for a study of environmental and occupational health personnel needs, because of its concern over the present and future status of our environmental and occupational health workforce.[1] To date, great resources, public and private, have been dedicated to activities pertaining to the identification, control and eradication of infectious diseases. We are beginning to expand and refine a new epidemiological concern: non-infectious diseases caused by human exposure to environmental contaminants. The Committee believes that personnel must be trained in a variety of disciplines to handle environmental problems affecting human health and that a Federal entity is needed to assess quantitatively and qualitatively the present environmental and occupational health workforce and to project workforce needs over the near and long term.

With the possible exception of the fields of environmental toxicology and environmental epidemiology, the Committee is not aware of crucial shortages of environmental or occupational health personnel at this time. However, the number of programs under environmental statutes such as the Clean Air Act, the Toxic Substances Control Act and the Resource Conservation and Recovery Act are just beginning to come to fruition and the Committee is concerned that there be a sufficient number of specialized, highly trained individuals to manage these programs. The Committee is also concerned that we have an adequate supply of personnel to develop, conceive and manage other Federal, State and local pollution assessment and control programs and to perform complementary research and support func-

[1] Broadly, environmental and occupational health personnel are described as those individuals involved in such diverse tasks as inspections and regulatory activities; oversight and enforcement of environmental and occupational laws and regulations; and the direction and management of programs dealing with the prevention, elimination, or control of environmental and occupational hazards to human health.

62-655 O - 80 - 7

tions in environmental medicine, the environmental health sciences, occupational medicine and toxicology.

This section directs the Secretary to study a wide range of workforce-related issues of interest to the Committee. The section directs the Secretary to perform an ongoing study to assess and identify current and projected personnel needs of the workforce of this country engaged in the implementation of environmental and occupational laws on the Federal, State and local level and to assess and identify the personnel needs of the workforce engaged in environmental and occupational health endeavors. For ease of reference the Committee hereafter will refer to both types of personnel as environmental and occupational health personnel. The Committee intends that the Secretary develop a permanent workforce assessment entity to study environmental and occupational health personnel issues on a continuing basis. The Committee also intends that the Administrator of the Environmental Protection Agency (EPA) and the Secretary of Labor work in conjunction with the Secretary and be partners in this endeavor.

The section also requires the Secretary to study a number of different workforce-related areas and report findings and recommendations to the Congress and to interested agencies two years from the date of enactment of the first appropriation for this section. The Committee expects such report to include recommendations susceptible to administrative implementation by interested agencies and departments and recommendations to the Congress for legislative action, if needed.

Specifically, the Secretary would be required to survey education and training programs and policies of Federal agencies with jurisdiction over, or interest in, environmental and occupational matters. The Committee is interested in an assessment of in-house training programs, university-affiliated programs, short-course training programs and multi-disciplinary training programs that permit individuals engaged in one discipline to learn about complimentary activities of individuals engaged in other disciplines.

Additionally, the Secretary would be required to study and assess the following:

Ways in which the Secretary and the Administrator of EPA could provide counsel and assistance to other Federal entities, States, and local governments to help them develop or refine a workforce planning capability;

The efficacy of the implementation by the Federal Government and the States of a register of personnel engaged in environmental and occupational functions;

Methods to encourage innovation in environmental and occupational curricula at educational and training institutions;

The adequacy of existing, and the need for additional, programs which provide specialized post-graduate training, cross-training or retraining for individuals engaged in environmental and occupational areas;

Areas of the country that are underserved by personnel in the environmental and occupational disciplines and remedies to perceived problems;

Mechanisms to stimulate entry into the disciplines of environmental and occupational health and to promote longevity in such disciplines (especially in the public sector).

The primary functon of the Secretary in executing his responsibilities under this section is to identify existing, and to anticipate future, shortages of personnel or deficiencies in expertise in the field of environmental and occupational health and take steps to remedy such existing or projected shortages or deficiencies. For example, several recent reports indicate there presently exists a shortage of adequately trained toxicologists.[2] [3] The Committee finds this particularly troublesome because since the end of World War II, our technological society has produced a wide variety of synthetic chemicals and other toxic elements, many of which find their way into our environment. Situations like Love Canal and the Valley of the Drums, where toxic materials have been disposed of in improper fashion, have caused documented harm to human health and the environment. However, we have only recently begun to assess the health effects of exposure to environmental contaminants and there is some indication that certain health personnel crucial to this process, such as toxicologists, are in short supply.[4] The Interagency Regulatory Liaison Group (IRLG)[5] performed an in-depth study of personnel needs in the field of toxicology, entitled "Research and Training in Toxicology for Fiscal Year 1980 and Beyond." The premise of the IRLG work is that no research program in environmental health will succeed unless adequate attention is given to the dynamics of the workforce that runs that program.

The Committee also intends that the Secretary shall help fashion and coordinate an environmental and occupational health manpower planning capacity within the Federal Government and shall advise and counsel States and local governments on the feasibility of creating, enhancing or refining such capacity at the State or local level. The Committee intends that the Secretary shall examine whether shortages of adequately trained environmental and occupational personnel exist in areas or regions of the country and whether certain regions of the country are underserved in terms of the existence in those regions of adequate educational and training institutions and facilities.

In conclusion, the Committee intends that the Secretary perform a rigorous assessment of our environmental and occupational health workforce and that the Secretary establish a permanent workforce assessment and projection capability. The Committee also expects prompt delivery of the specific elements mandated for study. However, the Committee also intends that the Secretary act with dispatch to remedy workforce problems by administrative action where he or she is empowered to do so and, where necessary, submit to Congress legislative solutions to existing or projected environmental and occupational workforce deficiencies.

---

[2] "Research and Training in Toxicology for Fiscal Year 1980 and Beyond," Interagency Regulatory Liaison group.

[3] "Continuing Education in Environmental Health," Dale Moeller, Harvard School of Public Health, October, 1979.

[4] "Training Scientists for Future Toxic Substances Problems," Conservation Foundation.

[5] This group consists of the Consumer Product Safety Commission, the Environmental Protection Agency, the Food and Drug Administration, the Food Safety and Quality Service of the Department of Agriculture, and the Occupational Safety and Health Administration. Its function is to improve the public health through sharing of information, avoiding duplication of effort and framing consistent regulatory policy.

PART G—ALLIED HEALTH PROFESSIONS

Background

During the mid-1960's, it became evident that the country was experiencing alarming shortages of allied health personnel. Advance in medical technology, lowered barriers to medical care, and sharp increases in population led to estimates that there was a shortage of professional technical and vocational workers that numbered in the hundreds of thousands.

President Johnson, in his 1965 health message to Congress, called, for the first time, for a Federal role in the education and training of allied health workers. Again in 1966, President Johnson asked the Congress for the enactment of a three-year program of grants for training in allied health programs:

> To construct and to improve needed educational facilities;
> To offer fellowships for students in advanced training; and
> To stimulate institutions to develop new types of health personnel.

The Congress responded to the President's call with the enactment of the Allied Health Professions Personnel Training Act of 1966 which authorized three years of Federal support, fiscal years 1967 through 1969, for construction grants, basic and special improvement grants, advanced traineeships, and "new methods" project grants for the development of curricula for the training of new types of health technologists.

The 1968 Health Manpower Act extended the allied health programs for one year and broadened the eligibility for the "new methods" grants for curricula development.

The Health Training and Improvement Act of 1970 was the first major revision of the allied health program. It extended for three years the authorities for construction, educational improvement grants, and traineeships. It replaced the "new methods" project grant authority with a broadened special grant authority for institutional improvement programs and for experimental or demonstration projects. The 1970 Act created two other new grant authorities: one to encourage the full utilization of financially, educationally, and culturally disadvantaged individuals, and the other to provide student assistance in the form of scholarships, work-study programs, and student loans. student loans.

The 1973 Health Programs Extension Act extended for one year the authorities for special improvement grants, special projects, traineeships for advanced training, and full utilization of educational talents, and terminated the authorities for construction grants, basic improvement grants, scholarship grants, and work-study and student loan assistance.

Various continuing appropriations Acts extended the allied health program authorities, until, in 1976, the Health Professions Educational Assistance Act extended the existing authorities through fiscal year 1977 and created a new three-part basic support program for fiscal years 1978 through 1980.

The first of the new authorities was Section 796: project grants and contracts to assist eligible entities in (1) establishing regional or State systems for the coordination and management of education and training for allied health personnel; (2) establishing new roles and functions for allied health personnel; (3) establishing new or improved methods of credentialing allied health personnel; (4) establishing methods of recruitment, training, and retraining; (5) establishing career ladders and programs for practicing allied health personnel; and (6) establishing continuing education programs for practicing allied health personnel.

The following table shows funding for the special projects programs in recent years.

TABLE 35.—ALLIED HEALTH SPECIAL PROJECTS FUNDING—1967–80

Fiscal year	Amount author. (millions)	Amount approp. (millions)	Amount awarded (millions)			Number of awards			MEDIHC program		
			Total	Cont.	New	Total	Cont.	New	Amount (millions)	Contr. awarded	Applic. received
1967–77	$381.1	$213.1	INA	INA	INA	INA	INA	INA	INA	INA	INA
1978	22.0	16.5	$17.1	$10.0	$7.1	331	236	95	$1.2	12	5,340
1979	24.0	10.5	10.3	8.2	2.1	262	243	19	1.2	12	[1] 5,200
1980	26.0	8.7	8.7	7.7	.4	163	149	10	.6	4	[1] 6,750
1981 [2]											

[1] Estimated.
[2] Expires.

Note: The average award per grant in fiscal year 1980 is $47,600.

Source: Department of Health and Human Services, Health Resources Administration, Bureau of Health Manpower.

The new section 797 authorized traineeships for advanced training of allied health personnel to teach in training programs and serve in administrative and supervisory positions.

TABLE 36.—ALLIED HEALTH TRAINEESHIPS

Fiscal year	Amount author. (millions)	Amount approp. (millions)	Amount awarded (millions)			Number of awards			Total continuing students	Long-term training	Short term training
			Total	Cont.	New	Total	Cont.	New			
1975–77	$15.9	$10.2	$10.2	$3.6	$6.6	270	90	180	8,973	1,298	7,675
1978	4.5	3.0	2.4	1.4	1.0	69	46	23	2,498	326	2,172
1979	5.0	2.5	2.5	1.5	1.0	80	45	35	3,401	292	3,109
1980	5.5	1.3	1.3	1.3		26	26		200	200	
1981	(1)										

[1] Expires.

Note: The average award per grant in fiscal year 1980 is $50,000.

Source: Department of Health and Human Services, Health Resources Administration, Bureau of Health Manpower.

A new Section 798 authorized educational assistance for disadvantaged individuals to (1) identify, recruit, and select such individuals with potential for training; (2) facilitate their entry into programs; (3) provide counseling and other services; (4) provide preliminary education; and (5) publish sources of available financial aid.

The 1976 Act also required the Secretary to prepare a report containing statistics and other information on allied health personnel,

including descriptions of the various types of personnel and their activities; current and anticipated needs for such personnel; and the number, employment, geographic locations, salaries, surpluses and shortages of such personnel.

This report, entitled A Report on Allied Health Personnel, was transmitted to the Congress on November 26, 1979, and released to the public in March of 1980. This report shows that, of the estimated 5.4 million health workers employed in the United States in 1978, 1,026,000 were allied health personnel as defined by the operations of the allied health professions assistance legislation first enacted in 1966. This number has grown from an estimated 442,000 in 1966, an increase of 132 percent, while the total health work force increased by only 76 percent in the same time period.

The years since the original enactment of the Allied Health Professions Personnel Training Act in 1966 have seen similar increases in the numbers of available education and training programs. Between 1964 and 1975, for instance, the number of college and university programs in allied health grew from approximately 2,000 to 6,900. In 1976, there were 145,000 graduates from these collegiate programs.

Hospital-based education and training programs in 1976 offered 3,300 different non-nursing allied health programs, in 1,600 institutions, graduating 35,000 students.

Other non-collegiate allied health programs in 1976 graduated 20,000 students, from 700 institutions, offering 1,300 programs.

The Secretary's report finds that, despite some progress, significant shortages are still apparent for many areas utilizing allied health personnel, particularly respiratory therapy, speech pathology, and audiology. Shortages may also still exist, to a lesser degree but provoking concern, of formally-trained dental assistants, and in dietetics, radiation therapy, and physical therapy.

The report also found that local or transitory shortages continue, even in occupations in which the overall national supply appears to be adequate—such as clinical laboratory personnel, radiologic technologists, and medical records personnel—a reflection perhaps of local labor market conditions, sometimes aggravated by geographic maldistribution of personnel.

The report noted a marked increase in the duties and responsibiilties of allied health personnel in recent years, and suggests an increased use of such personnel as a cost-savings strategy, particularly in HMO's and long-term care.

The report found an increase in the regulation of allied health personnel through licensure, certification, and third-party payment requirements. It also found that current methods of setting standards for individual performance, and of determining whether persons meet those standards, generally are not satisfactory. The report states that the quality of training has increased significantly in recent years, but that further improvements are required. It noted an ongoing concern for the continued competency of allied health workers, particularly for those returning to work after an interruption in their career.

The report concluded that insufficient data about allied health personnel at the local, State, and national level make radical improve-

ments in planning, production, and management difficult. Insufficient data and other problems also make it difficult to assess the impact of Federal support for allied health personnel.

The W. K. Kellogg Foundation, in 1977, warded a grant to a fund a study by the National Comimssion on Allied Health Education. The Commission's report, entitled The Future of Allied Health Education, was published in March 1980, and lists 15 primary recommendations the Commission felt that allied health education should implement to improve its quality, accessibility, continuity, and cost-effectiveness. The most critical of these, according to testimony before the Committee, in March 1980, is the last recommendation, that "significantly increased funding for allied health should be provided at the Federal, State, and local levels, and from private resources." According to that testimony, "absent the recommended increase, the achievement of any of the remaining 14 . . . is impossible."

2. Proposed legislation

In H.R. 7203, the Committee proposes to extend the programs of support for allied health personnel contained in Title VII of the Public Health Service Act. The Committee is concerned that comprehensive statistical information on allied health professionals is lacking and asks the Department of Health and Human Services to increase its efforts at collection and analysis of data relating to the supply, costs, and distribution of this work force. Despite this lack of comprehensive data, reports to the Committee have shown programs supported under these allied health sections and their predecessors to have achieved some success in reducing many of the national shortages in allied health professions. The Committee, in extending existing program authority, expects that similar progress will be made in those specialties which are yet experiencing shortages of personnel—which, according to information supplied to the Committee, include respiratory therapy, speech pathology, audiology, and professionals to aid in the rehabilitation and mobility of the blind. The Committee anticipates that new administrative initiatives in monitoring and stimulating the supply of these personnel will be undertaken under the project's authority.

The Committee has also received reports on the special needs of rural and small health care institutions. While it recognizes that national shortages have been alleviated, the Commit tee is disturbed by the critical shortages in these institutions and by the problems of distribution in certain geographic areas and rural and urban settings. Several Federal programs begun in recent years have demonstrated qualified achievement in placing trained personnel in underserved areas and the Committee intends that these be continued, expanded, and improved.

Finally, the Committee agrees with reports of the Department of Health, Education, and Welfare that the regulation, licensure, and expanded use of allied health professionals should be done with careful cost consciousness. Under private and Federal influence, specialty and sub-specialty classifications and guilds have proliferated. The Department of Health, Education, and Welfare has noted that this proliferation has been accomplished with little long-range planning, cost control, or attention to efficiency. The Committee intends that proj-

ects for improvement in the quality of allied health care delivery be continued, but it further intends that this continuation be effected with a special concern for the ultimate health costs.

Title III—Nurse Training

1. Background

The original program of Federal support for professional nurse training was limited to traineeship authority autorized under the Health Amendments Act of 1956 (Public Law 84–911), designed to provide support for professional nurses enrolled in programs which would qualify them to teach or fill administrative and supervisory positions in hospitals and other health care facilities. Subsequently, the Congress, in recognition of the limited physical capacity of collegiate schools of nursing to provide educational facilities for the advanced training programs assisted under the 1956 Act, provided grant support for the construction, expansion, or modernization of collegiate schools of nursing by enacting the Health Professions Educational Assistance Act of 1963 (Public Law 88–129).

By the late 1950's and early 1960's there began to be increasing concern that existing and potential shortages in the nursing professions were not limited to that segment of the profession requiring advanced training. In 1961, 23 percent of the available nursing positions in hospitals were unfilled; over half of the nursing positions in public hospitals in New York City were vacant; 1 out of every 10 skilled nursing facilities had no nursing staff. The Consultant Group on Nursing, appointed by the Surgeon General in 1961 at the direction of the President to provide advice on nursing needs and to identify the appropriate role of the Federal Government in assuring an adequate supply of nursing personnel, reported that, unless the supply of nurses was substantially increased, the Nation would face a shortage of nearly 300,000 nurses by 1970. The group also recommended an expansion in the number of students being trained in collegiate schools such that by 1980, at least one third of the active professional nurses in the United States would have been trained in such schools.

On February 10, 1964, President Lyndon B. Johnson, in his health message to the Congress, made the following statement with respect to the nursing profession:

The rapid development of medical science places heavy demands on the time and skill of the physician. Nurses must perform many functions that once were done only by doctors.

A panel of expert advisers to the Public Health Service has recommended that the number of professional nurses be increased from the current total of 550,000 to 680,000 by 1970.

This requires raising nursing school enrollments by 75 percent.

But larger enrollments alone are not enough. The efficiency of nursing schools and the quality of instruction must be improved. The nursing profession, too, is becoming more complex and exacting.

The longer we delay, the larger the deficit grows, and the harder it becomes to overcome it.

I recommend the authorization of grants to build and expand schools of nursing, to help the schools perfect new teaching methods, and to assist local, State, and regional planning for nursing service.

We must remove financial barriers for students desiring to train for the nursing profession and we must attract highly talented youngsters.

I therefore recommend Federal loans and a national competitive merit scholarship program. For each year of service as a nurse up to 6 years a proportion of the loan should be forgiven.

In addition, I recommend continuation and expansion of the professional nurse traineeship program to increase the number of nurses trained for key supervisory and training positions.

The Nurse Training Act of 1964 (Public Law 88–581), which established the first comprehensive program of Federal support for nursing education, was enacted in response to the Consultant Group's report and the President's recommendations. It authorized a balanced program of Federal assistance to students and schools professional nursing, including grants for the construction of nursing education facilities contingent upon upon expansion of enrollment; special project grants to improve the quality of nursing education; formula grants to diploma schools which agreed to increase enrollment; and low interest, partially cancellable, loans for nursing students. The traineeship authority of the 1956 Act was incorporated into the new title and expanded to include advanced preparation in clinicial specialties, and the separate construction authority for collegiate schools authorized under Public Law 88–129 was repealed.

Subsequent enactment in 1966 (Public Law 89–751), 1968 (Public Law 90–490), and 1971 (Public Law 92–158) added new authorities to the program, including contracts to encourage the recruitment of individuals from disadvantaged backgrounds, grants and scholarships for nursing students, basic institutional support grants (based on the product of the number of students enrolled in the school and $250 and thus referred to as capitation grants) to schools of nursing which agreed to increase their enrollments, financial distress grants for schools in financial difficulties, and start-up grants for new training programs.

The last substantive revision of the nurse training authorities under the Public Health Service Act, the Nurse Training Act of 1975 (Public Law 94–63), represented a reaffirmation of the Congressional commitment to Federal support for nurse training activities at all levels of training and in each type of school of nursing. Its provisions had been pocket-vetoed by then-President Ford following the adjournment of the 93rd Congress and vetoed again early in the 94th Congress on the grounds that it was no longer necessary to provide support for nursing education. The vote by the House of Representatives in overriding the President's veto (384–43) was a strong indication of commitment of the Congress to continuing such support.

Construction.—The 1975 Act extended the authority for construction grants, and specified that projects intended to expand the capacity of a nursing school to provide graduate training were eligible for such grants. Since 1975, there has—with one exception—been a general moratorium on new construction awards.

Capitation grants.—It also revised and extended the authority of the Secretary of HEW to make annual capitation grants to schools of nursing. A collegiate school was eligible to receive $400 per student enrolled in each of the last 2 years of such schools, an associate degree school was eligible to receive the product of $275 and one-half of the students enrolled in the first year of such school and $275 for each student enrolled in the second year of such school, and a diploma school was eligible to receive $250 for each student enrolled in the school. In order to be eligible to receive such a grant, a school is required to increase its enrollment by a specified number of students depending on the size of the school or undertake two of four stipulated special projects—train nurse practitioners, provide remote site training opportunities for its students, operate program of continuing education, or operate a program to enroll and graduate individuals from disadvantaged backgrounds.

Experience under the capitation grant program demonstrates that it has been a successful tool to stimulate nursing school enrollment. From 1964 to 1970, prior to the inception of the capitation grant program, nursing school enrollment increased by less than 18,000 students; from 1970 to 1976, however, the increase in enrollment nearly doubled to 34,000 students.

Capitation grants have also had a direct impact on the national health goals of primary care, manpower production and distribution, and manpower quality and competency. In 1979, nineteen of the collegiate schools of nursing had elected to operate programs for the training of nurse practitioners in such primary care fields as pediatrics, geriatrics, family health, nurse midwifery, community health, and emergency care. Two hundred and seventeen schools planned programs of remote site training, 174 schools provided continuing education courses for professional nurses, and 146 schools submitted plans to enroll and retain students from disadvantaged backgrounds.

Financial distress.—It continued the authority for financial distress grants available to schools of nursing to meet operational costs necessary to maintain quality educational programs or to meet accreditation requirements. No awards have been made under the authority since fiscal year 1975.

Special project grants contracts.—It continued the authority for special project grants and contracts to improve nursing education, including projects to assist in developing cooperative arrangements between or mergers of hospital training programs and academic institutions; to improve curricula; to increase educational opportunities for individuals from disadvantaged backgrounds; to provide continuing education to active nurses; to provide retraining opportunities for inactive nurses wishing to re-enter the practice of nursing; to increase the supply or improve the geographic or specialty distribution of nursing personnel; to upgrade the skills of paraprofessional nursing personnel, and to assist in meeting the costs of developing short-term, in-service training programs for nurses' aides and orderlies employed in nursing homes. Presently funded at $15 million, the authority supported approximately 158 grants and five contracts in 1979.

Advanced nurse training programs.—It added a new authority for project grants and contracts to collegiate schools of nursing to plan,

develop, and operate, significantly expand or maintain existing programs for the advanced training of professional nurses to teach in the various field of nursing, to serve in administrative or supervisory capacities, or to serve in other nursing specialities.

Over the past 3 fiscal years, advanced nurse training awards have assisted a wide range of special educational programs, including programs which concentrate on providing nursing services to specific age groups or in increasingly complex situations, programs in clinical nursing research, and programs applying behavioral and social sciences to nursing practice. The awards have also provided much needed support to programs offering broad-based doctorates in nursing and for those offering master's programs in advanced general nursing science. Several projects have focused on providing outreach opportunities for graduate education in areas remote from a central campus. The following table shows the numbers of projects supported in fiscal year 1979.

TABLE 37.—*Advanced nurse training projects, fiscal year 1979*

Grant areas of support:	*Number being supported*
Maternal-child nursing	27
Medical-surgical nursing	25
Geriatric nursing	19
Administration	17
Community health nursing	17
Teaching	10
Adult health nursing	8
Acute care nursing	4
Other	12

Nurse practitioners.—Finally, in recognition of the potential nurse practitioners have for improving the quality of and access to health care, the 1975 Act included a new authority for project grants and contracts to meet the costs of programs for the training of nurse practitioners which programs met guidelines prescribed by the Secretary.

In fiscal year 1979, 83 of the 198 nurse practitioner training programs were supported under this authority. Approximately 1,000 practitioners are graduated annually, and almost half of these graduates are employed in underserved rural or urban areas.

Traineeships for advanced nurse training.—It continued the authority to provide grants to public or nonprofit private institutions to cover the costs of traineeships for the advanced training of professional nurses, and specified that individuals enrolled in nurse practitioner programs were eligible for such traineeships. During fiscal year 1979, the $13 million available provided support for approximately 2,500 trainees enrolled in programs leading to master's and doctoral degrees at 113 participating institutions.

Student loans and scholarships.—It continued the authority to provide low interest student loans, authorized professional nurses training to become nurse anesthetists to defer repayments of such loans until such training was completed, and continued, without change, the authority to make grants to schools of nursing for scholarships to students of exceptional financial need. The following tables provide more detailed information on the number of students assisted under the student loan and student scholarship authorities by type of program.

TABLE 38.—NURSING STUDENT LOAN PROGRAM, ACADEMIC YEARS 1977–80

	Schools	Participating enrollment	Amounts requested	Amounts allocated	Students assisted	Percent of students assisted
Academic year 1976–77:[1]						
Associate	491	76,659	$26,457,610	$6,914,185	8,642	11.0
Baccalaureate	359	117,759	47,845,033	11,164,002	13,955	11.0
Diploma	257	42,571	10,426,492	3,771,012	4,714	11.0
Graduate	86	6,794	3,898,184	627,765	785	11.0
Total	1,193	243,783	88,377,006	22,476,964	28,096	11.0
Academic year 1977–78:[1]						
Associate	503	76,093	25,118,864	6,795,031	8,494	11.0
Baccalaureate	373	117,241	47,746,126	11,217,931	14,022	12.0
Diploma	238	39,003	9,162,808	3,624,907	4,531	11.0
Graduate	91	7,347	4,147,849	666,310	833	11.0
Total	1,205	239,684	86,175,647	22,304,179	27,880	11.6
Academic year 1978–79:[1]						
Associate	501	75,012	22,707,837	6,584,843	8,231	11.0
Baccalaureate	375	118,815	49,039,406	11,549,838	14,437	12.0
Diploma	222	34,729	8,097,041	3,363,043	4,204	12.0
Graduate	91	8,468	4,374,977	784,436	981	11.0
Total	1,189	238,024	84,219,261	22,282,160	27,853	12.0
Academic year 1979–80:[1]						
Associate	498	72,108	20,997,870	4,047,433	5,060	7.0
Baccalaureate	371	111,983	46,976,281	6,920,856	8,651	8.0
Diploma	207	31,297	8,047,559	1,936,318	2,420	8.0
Graduate	91	8,920	4,787,324	460,393	575	6.0
Total	1,167	224,308	80,809,034	13,365,000	16,706	7.0

[1] Enrollments and students assisted are estimated.

TABLE 39.—NURSING SCHOLARSHIP PROGRAM, FISCAL YEAR 1977, ACADEMIC YEARS 1977–78, 1978–79, 1979–80

	Schools	Participating enrollment	Amounts requested	Amounts allocated	Students assisted	Percent of students assisted
Fiscal year 1977:[1]						
Associate	573	87,808	$19,600,700	[2] $2,048,755	2,049	2.0
Baccalaureate	369	120,229	28,772,111	2,790,188	2,790	2.0
Diploma	268	43,651	8,231,265	1,005,543	1,006	2.0
Graduate	86	6,834	1,826,395	155,514	155	2.0
Total	1,296	258,522	58,430,541	6,000,000	6,000	2.0
Academic year 1977–78:[1]						
Associate	585	86,831	19,797,455	2,215,018	2,215	3.0
Baccalaureate	385	119,760	28,354,518	3,052,113	3,052	3.0
Diploma	244	39,688	7,274,490	984,524	985	2.0
Graduate	88	7,222	1,758,439	176,064	176	2.0
Total	1,302	253,501	57,184,902	6,427,719	6,428	2.5
Academic year 1978–79:[1]						
Associate	592	87,012	19,124,558	3,028,517	3,028	3.4
Baccalaureate	391	121,650	28,739,651	4,315,683	4,316	3.5
Diploma	237	37,659	6,924,263	1,280,364	1,280	3.4
Graduate	90	8,418	2,085,900	289,750	290	3.4
Total	1,310	254,739	56,874,372	8,914,314	8,914	3.5
Academic year 1979–80:[1]						
Associate	597	85,105	18,917,116	3,081,565	3,082	3.6
Baccalaureate	406	118,081	31,093,557	4,339,312	4,339	3.7
Diploma	223	33,153	6,261,402	1,190,943	1,191	3.6
Graduate	91	8,911	2,003,460	298,180	298	3.3
Total	1,317	245,250	58,275,535	8,910,000	8,910	3.6

[1] Enrollments and students assisted are estimated.
[2] Transition quarter funds.

In October 1978, the 95th Congress overwhelmingly adopted legislation which provided a two-year reauthorization for expiring authorities with respect to nurse training. That legislation provided authorization for appropriations for fiscal years 1979 and 1980 at the 1978 authorization level, except that it did increase the anual authorization for special project grants and contracts by $5 million; did not extend the authority for financial distress grants for nursing schools, and did authorize traineeships for training nurse anesthetists. That bill was vetoed by President Carter on November 11, 1978. Programs of nurse training were continued in fiscal year 1979 under a continuing resolution, Public Law 95–482. Subsequently, fiscal year 1979 appropriations for programs of nurse training were reduced under the provisions of Public Law 96–7, the Budget Authority Rescission Act of 1979.

A one-year reauthorization of the nurse training authorities was enacted in 1979 (Public Law 96–76). The financial distress provisions were, however, not continued. In addition, a program of traineeships for the training of nurse anesthetists was authorized for the first time. Authorizations of appropriations were made in the amount of $103 million for fiscal year 1980 for all programs under Title VIII. Such a short extension was adopted for several reasons, among them the perception that in order to develop a consistent Federal policy for all health professions schools and students it was necessary to consider nursing education support in conjunction with the 1980 examination of all other programs of health professions assistance. Toward this end, Public Law 96–76 also required the Secretary of Health, Education, and Welfare to arrange for a study by the Institute of Medicine of the National Academy of Sciences. That study was to include (1) a determination of the need to continue a specific program of Federal financial support for nursing education, (2) a determination of the reasons nurses do not practice in medically underserved areas and recommendations for action, and (3) a determination of the rate at which and the reasons for which nurses leave the nursing profession and recommendations for action. The premilinary results of the study are not yet available.

2. Proposed legislation

The Committee's proposals for programs to support and aid nursing education arise from basic concerns about the adequacy of the nursing work force at present and in the future. The Committee had required, in its 1979 Amendments, that the Secretary of Health, Education, and Welfare enter into an agreement with the Institute of Medicine of the National Academy of Sciences to conduct a study of the need for and best form in which to provide continued Federal support for nursing education for use in its consideration of this legislation and is disturbed that this study has been repeatedly and unnecessarily delayed. The Commitee has, however, received much other information on these problems and is of the opinion that Federal programs of assistance must be continued and strengthened to ensure the appropriate supply, quality, and distribution of nurses throughout the country.

To increase the number of nurses, the Committee bill would revise and extend several programs supported under Title VIII of the Pub-

lic Health Service Act. The provisions of H.R. 7203, as reported by the Committee, include an extension of the institutional support (capitation) program to nursing schools, which is calculated on the basis of the numbers of students these schools enroll, as well as a program option that would require a renewed effort to increase enrollment. The Committee also proposes an extension of the loans and scholarship programs for nursing students to make this increasingly expensive training accessible to lower- and middle-income students. The Committee recommends the extension of the authority for special projects to increase the enrollment of students from disadvantaged backgrounds, and H.R. 7203, as reported, requires that such projects receive no less than twenty percent of the funds appropriated under the special projects authority. Such programs have been notably underused and improperly developed in the past and it is the Committee's intent that new and vigorous efforts be made to recruit and train disadvantaged students.

While the Committee is not of the opinion that all nursing personnel must possess identical degrees or highly sophisticated training in order to perform adequately, it does recognize that there is an increased and increasing need for nurses educated in new forms of practice, in program management, and in teaching activities. In an effort to aid nursing schools in meeting these needs, the Committee proposes various forms of assistance to institutions and students. An undergraduate program is made eligible to receive institutional support if a specified percentage of its entering class possesses some previous nursing degree and its to be in training for a higher degree. It is the Committee's intent that such programs serve both to provide career direction for individuals and to supply nurses to fill the personnel requirements of health care delivery systems. Toward these same ends, the Committee proposes the extension of authority for special projects in continuing education and re-training. H.R. 7203, as reported, would also extend the program of support for students who are in programs of advanced nurse training. The Committee has heard testimony relating to the need for nurse-midwives and intends that these nursing specialists be aided through this program. The Committee further recognizes the need for nurse educators and intends that at least half of the money appropriated for these traineeships go to students who plan to teach in fields of nursing.

In its consideration of appropriate Federal involvement in nursing education, the Committee is not unmindful of arguments presented that the numbers of nurses are adequate but that the work force is subject to severe problems of maldistribution. While the Committee believes that the supply of nurses is inadequate, it is of the opinion that there are significant dispartities in the distribution of nurses among geographic areas. The Committee has, therefore, specified that the limited construction authorizations made in H.R. 7203 may be used only for projects within health manpower shortage areas. The Committee recommends the extension of programs to train nurse-practitioners and proposes certain changes in the nurse-practitioner traineeships program to make more effective the provisions requiring service within a health manpower shortage area.

The Committee also recommends that the special projects authority relating to distribution of nursing personnel be extended. The Committee feels that this authority has been used insufficiently in the past, and H.R. 7203 would require that no less than twenty percent of the funds appropriated under the general special projects authority be used for projects relating to distribution.

Title IV—Graduate Medical Education National Advisory Committee

1. Background

Between 1974 and 1976, during consideration of the extension and review of health manpower training programs contained in Title VII of the Public Health Service Act, Congress noted with concern problems associated with the distribution of health professionals—across the Nation geographically and by specialty. During this time, several proposals were considered which would regulate the number and distribution of residency training programs and positions in order to correct a perceived maldistribution of physicians by specialty.

Provisions were included in the Health Professions Eduactional Assistance Act of 1976 to increase the supply of primary care physicians. In order to receive capitation assistance, medical schools were required under this law to have specified percentages of filled first-year residency training positions in direct or affiliated primary care training programs. For 1980 grants, medical schools are required to have 50 percent of filled first-year positions in family medicine, general internal medicine, or general pediatrics. The 1976 statute, in addition, authorized special project grants for training in family medicine and the general practice of dentistry, as well as other grants for training in general internal medicine and general pediatrics.

Coincident with the consideration of the issue in the 94th Congress, on November 21, 1975, the Secretary of the Department of Health, Education and Welfare submitted to the Speaker of the House of Representatives a plan to establish an Advisory Council on Graduate Medical Education using existing authority under section 222 of the Public Health Service Act relating to Advisory Councils or Committees. Subsequently, the Graduate Medical Education National Advisory Committee (GMENAC) was chartered by the Secretary of HEW on April 20, 1976, to make recommendations to the Secretary on the present and future supply of and requirements for physicians.

More specifically, GMENAC has been charged with the responsibility of advising the Secretary on strategies to achieve an appropriate number of physicians in each specialty, to assure adequate financing mechanisms for graduate medical education, and to achieve a proper utilization of other categories of complementary manpower. It is also required to evaluate available physician manpower data and research findings and recommend ways to improve both. The charter of GMENAC has been renewed by the Secretary for a term extending through September 1980.

An Interim Report was published by GMEMAC in April 1979. This report provides background material, including the data bases and analytic plan, for discussion of the question of whether the future supply and distribution of the Nation's physicians can be improved by effecting changes in the number and distribution of specialty training positions available to medical school graduates. The premise of the work of GMENAC is that the supply and distribution of specialty training positions available to medical school graduates will directly influence the future supply of specialists. The Interim Report notes:

> Modification of the number and distribution of these positions may become an important influence on the future supply of physicians. Understanding the relationship between the graduate medical education system and the future supply and distribution of physicians is one critical aspect of the committee's work. Pursuit of this level of understanding has led the committee to undertake extensive analyses and developmental efforts to model the present and future physicians training pipeline and the present and future supply of the requirements for practitioners in 108 medical and surgical specialties and areas of competence. Other means to influence manpower supply are also being studied, such as changes in the reimbursement system and changes in the educational environment.[1]

GMENAC has adopted 1990 as the target year for its projections and recommendations regarding physician specialty manpower requirements. The Committee's Interim Report has pointed out that by 1990, about 30 percent of the current supply of physicians will have left the physicians pool owing to death, retirement, or other reasons; and approximately 45 percent of the 1990 physician pool would have begun practice after 1977.

> This turnover represents a significant opportunity for affecting any needed change and will permit sufficient time for the evaluation of such changes that are implemented.[2]

2. Proposed legislation

The Committee believes that the distribution of physicians by specialty is one of the most important issues facing the health care system today. With a major increase in the supply of physicians projected for the years ahead, it is important that the nation now train medical specialists to provide a proper balance of such specialties.

In the past decade a variety of studies by both individuals and organizations have suggested that the nation may not be training an adequate number of primary care physicians. As noted previously, in June of 1973 the House of Delegates of the American Medical Association adopted a recommendation that the need for more primary care physicians should be accepted as fact. Also in 1973, the

---

[1] Interim Report of the Graduate Medical Education National Advisory Committee for the Secretary, Department of Health, Education, and Welfare. April 1979, p. xiii.
[2] Ibid., p. 321.

Graduate Medical Education Committee of the Association of American Medical Colleges recommended that additional medical students enter training programs in the primary care specialties. In January of 1975, the Coordinating Council on Medical Education—a body made up of the American Board of Medical Specialties, the American Hospital Association, the American Medical Association, the Association of American Medical Colleges, and the Council on Medical Specialty Societies—also recommended that additional graduating medical students enter careers in primary care. Finally, the Institute of Medicine, in its 1978 "Report A Manpower Policy for Primary Health Care," asserted that more new physicians should be primary care practitioners.

The Committee has also received reports that there may be a shortage of physicians in other specialties such as psychiatry, physical medicine, and rehabilitation.

A number of questions have been raised by studies concerning the specialty distribution of physicians. Many questions relate to the lack of reliable data concerning both practicing physicians and physicians in postgraduate training. In addition, the absence of a sophisticated system to project future physician supplies by specialty and geographic areas has posed problems. In this regard, it is significant that most of the committees that have reviewed the specialty distribution question have issued their reports and then have been disbanded. No group has remained in existence to refine further its data, to develop better projections or to issue a second generation report, in response to concerns about an initial work.

The Committee thus proposes to provide statutory authority for the existing Graduate Medical Education National Advisory Committee (GMENAC). This authority insures that GMENAC will continue to study the many questions relating to the proper distribution of physicians by specialty after it issues its initial report this fall. Because of limitations of the data available to GMENAC the Committee anticipates that further analysis of a number of specialty areas will be necessary. In addition, comments on the analysis and recommendations of GMENAC by interested individuals and organizations will be both inevitable and appropriate.

The Committee thus expects that GMENAC will, in future years, continue to work with the individuals and organizations in the various specialty areas to refine its data, projections, and recommendations concerning those specialties. The Committee especially emphasizes the need for continuing the collection and maintenance of better data concerning both practicing physicians and physicians in training.

In order to insure that the work of GMENAC will proceed without discontinuity, the provisions of the Committee proposals are adapted from GMENAC's existing charter. Provisions are also made for current members to continue to serve on GMENAC through the completion of the terms of their appointments.

The Committee notes that the membership of GMENAC has always been drawn from leaders in the fields of medicine, medical education, and health care administration. At the time of the issuing of its Interim Report, for example, 17 of the 23 members were MD's and DO's.

62-655 O - 80 - 8

The remaining members were drawn from the health insurance industry, health planning agencies, and labor unions. The Committee anticipates that the traditional background of GMENAC members will continue in the future.

In order to strengthen further the ability of GMENAC to draw upon the experience of leaders in the field of medicine the Committee proposal instructs GMENAC to consult with the Coordinating Council on Medical Education. To promote effective working arrangements between GMENAC and the CCME, the Chairman of the CCME is required to be an ex-officio member of GMENAC and provision is made for GMENAC to contract with the CCME, among other entities.

The Committee also anticipates that GMENAC will work in an appropriate manner with the equivalent body or bodies established by the osteopathic medical profession.

In conclusion, the committee believes that the activities of GMENAC, as specified in this legislative proposal, will permit the orderly review and constructive response to questions concerning the specialty distribution of physicians in the years ahead. Such a response can only lead to a more efficient and effective health care system.

Program Oversight

The Committee's principal oversight activities with respect to the program authorities in this bill were conducted by the Subcommittee on Health and the Environment in connection with its consideration of this legislation. Oversight hearings on the National Health Service Corps were held by the Subcommittee on Health and the Environment on January 30, 1980 (Serial No. 96–109). Legislative hearings on the extension proposals contained in this bill were conducted on March 20, 21, 24, 26, and 27, 1980. The proposed legislation is designed to respond to the Subcommittee's findings. The Committee has not received reports from its own Subcommittee on Oversight and Investigations or the Committee on Government Operations.

Inflation Impact Statement

The Committee is unaware of any inflationary impact on the economy that would result from the passage of the proposed legislation. The reported bill provides authorizations of appropriations for fiscal year 1981 of $649.3 million. This is in sharp contrast to the corresponding fiscal year 1980 authorization which exceeds $1 billion.

Furthermore, unlike most Federal grant programs, some of the money authorized under this proposal will be recouped by the Federal government. For example, student loans authorized under this legislation must be repaid, and many entities to which National Health Service Corps personnel are assigned must repay to the Federal government, from collections received from services provided by Corps personnel, the pay and allowances of such personnel as well as the amount of National Health Service Corps scholarship support such assignees may have received.

Finally, the provisions of this proposal which encourage the training of primary care physicians will ensure the availability of health care providers who are trained to emphasize ambulatory care services rather than more costly secondary and tertiary care services which are all too often required today.

Agency Reports

Agency reports were requested on H.R. 6802, a similar predecessor bill to H.R. 7203 on March 14, 1980, from the Office of Management and Budget; the Department of Health, Education and Welfare; the Department of the Treasury; the Department of Justice; and the International Communications Agency, but as of the date of filing no reports had been received.

Congressional Budget Office Cost Estimate

A cost estimate was requested on H.R. 7203 when it was ordered reported from the Committee on Interstate and Foreign Commerce, and the Congressional Budget Office has provided the following information:

Congressional Budget Office,
U.S. Congress,
Washington, D.C., May 13, 1980.

Hon. Harley O. Staggers,
Chairman, Committee on Interstate and Foreign Commerce, U.S. House of Representatives, Washington, D.C.

Dear Mr. Chairman: Pursuant to section 403 of the Congressional Budget Act, the Congressional Budget Office has prepared the attached cost estimate for H.R. 7203, the Health Professions Educational Assistance and Nursing Training Amendments of 1980.

Should the Committee so desire, we would be pleased to provide further details on this estimate.

Sincerely,

Alice M. Rivlin,
Director.

Attachment.

May 13, 1980.

COST ESTIMATE

1. Bill number: H.R. 7203.
2. Bill title: Health Professions Educational Assistance and Nurse Training Amendments of 1980.
3. Bill status: As ordered reported by the House Committee on Interstate and Foreign Commerce on May 7, 1980.
4. Bill purpose: This legislation is designed: (1) to revise and extend programs of the National Health Service Corps; (2) to revise and extend programs of assistance for health professions education and training under Title VII of the Public Health Service Act; (3) to revise and extend programs of assistance for nurse training under Title VIII of the Public Health Service Act; and (4) to establish statutorily the Graduate Medical Education National Advisory Committee.

5. Cost estimate:

[By fiscal years, in millions of dollars]

Authorization level	1981	1982	1983	1984	1985
National Health Service Corps	94	145	205	----------	----------
National Health Service Corps scholarships	92	101	109	----------	----------
Health professions:					
Health facilities construction	15	----------	----------	----------	----------
Loans for teaching facility construction (estimated)	4	4	4	----------	----------
HEAL loans (estimated)	(1)	(1)	(1)	(1)	(1)
HPSL loans	20	22.5	25	----------	----------
Exceptional need scholarships	30	40	50	----------	----------
Capitation grants	67.952	48.631	29.316	----------	----------
Departments of family medicine	15	20	25	----------	----------
Area health education centers	21	28	30	----------	----------
Physician and dental assistants	14	15	16	----------	----------
General medicine and pediatrics—Training and traineeships	23	30	32	----------	----------
Family medicine and general practice dentistry	50	75	80	----------	----------
Disadvantaged individuals	30	33	36	----------	----------
Institutions	10	12.5	15	----------	----------
Financial distress	20	20	20	----------	----------
Environmental and occupational health personnel study	1	1	1	----------	----------
Public health traineeships	8	9	10	----------	----------
Special projects—Public health	5	5.5	6	----------	----------
Midcareer training	1.5	2.5	3	----------	----------
Graduate programs in health administration	4	4.5	5	----------	----------
Health administration traineeships	2.5	3	3.5	----------	----------
Department of preventive medicine	2	3	4	----------	----------
Residency training in preventive medicine	6	7	8	----------	----------
Special curriculum development for health administration	3	4	5	----------	----------
Faculty development programs	1	1	1	----------	----------
Allied health project grants	9	9.5	10	----------	----------
Allied health traineeships	1.3	1.4	1.5	----------	----------
Allied health assistance to disadvantaged individuals	1	1	1	----------	----------
Nurse training:					
Construction grants	1	1	1	----------	----------
Capitation	25	27.5	30	----------	----------
Special projects	15	17.5	20	----------	----------
Advanced nurse training	12	13.5	15	----------	----------
Nurse practitioner	17	18.5	20	----------	----------
Advanced nurse traineeships	15	17.5	20	----------	----------
Nurse anesthetists traineeships	2	3	4	----------	----------
Student loans	15	17.5	20	----------	----------
Scholarships (estimated)	31	55	66	40	16
Total	684.252	818.031	931.316	40	16
Estimated outlays	153	523	824	669	301

[1] Less than $500,000.

The costs of this bill fall within budget function 550.

6. Basis of estimate: For most of the programs the authorization levels are stated in the legislation. Authorizations for interest subsidies for past loans for construction of teaching facilities were provided by HHS and appear reasonable. Guarantees for new loans for renovation projects would probably not result in federal costs for the first five years; therefore, estimated authorizations are zero. Estimated authorizations for the HEAL program are insignificant. Authorization levels for the nurse training scholarships were calculated using the funding formula stated in the legislation. The number of additional students for whom scholarship grants would be available was derived by applying HHS estimates of completion rates for students in the different nursing programs to CBO's latest projections of nursing school enrollments.

The authorizations for the National Health Service Corps (NHSC) would provide funds for 2,958 corps members in 1981, 3,881 corps members in 1982, and 5,073 corps members in 1983. It is possible that by 1983, 30 percent of former scholarship students becoming eligible

for assignment would take advantage of the liberalized private practice option. If that were to occur, NHSC costs in 1983 could fall by about $20 million without reducing the number of practitioners (in the NHSC and private practice) in underserved areas. The provisions allowing the Secretary to assign people to nonfederal organizations should have similar but smaller effects.

Outlays are based on historical program spendout rates for these programs. In each case outlays are calculated assuming that authorizations will be fully appropriated at the beginning of each fiscal year.

7. Estimate comparison: None.
8. Previous CBO estimate: None.
9. Estimate prepared by Dave Longanecker and Larry Wilson.
10. Estimate approved by:

C. G. Nuckols
(For James L. Blum,
Assistant Director for Budget Analysis).

Section-by-Section Analysis

H.R. 7203—HEALTH PROFESSIONS EDUCATIONAL ASSISTANCE AND NURSE TRAINING AMENDMENTS OF 1980

Sec. 1—Short Title; Reference to Act; and Table of Contents.

Sec. 1(a) provides the Act's short title, "Health Professions Educational Assistance and Nurse Training Amendments of 1980."

Sec. 1(b) provides that any reference to an amendment to or repeal of a Section shall be considered to be made to a section or other provision of the Public Health Service Act.

A Table of Contents for this Act follows Sec. 1(b).

TITLE I—NATIONAL HEALTH SERVICE CORPS PROGRAMS REVISION AND EXTENSION OF NATIONAL HEALTH SERVICE CORPS

Sec. 101(a)(1) amends Section 331(a)(1) of the Public Health Service Act to include as members of the National Health Service Corps (in addition to designated Officers of the Public Health Service and appointed civilian employees of the United States) such other individuals who are not employees of the United States but who are employees of the entities to which they are assigned by the Secretary.

Sec. 101(a)(2) amends Sec. 331(d) of the Public Health Service Act to exempt those individuals who are Members of the Corps but who are not employees of the United States from pay regulations of the Secretary and to require that such individuals, when assigned to another service entity, be subject to the personnel system of that entity (except that the individual shall be entitled to receive an income equal to that which would have been received had he remained a civilian employee of the United States appointed to the Corps.)

Sec. 101(a)(3) amends Sec. 331(h)(1) of the Public Health Service Act to redesignate the Department of Health, Education and Welfare as the Department of Health and Human Services.

Sec. 101(a)(4) amends Sec. 331 of the Public Health Service Act to require the Secretary to prescribe conversion provisions for those

members of the Corps who are not employees of the United States who, within one year after completing their service, become Commissioned officers in the Public Health Service. One such provision would entitle such an individual to credit for the period of such service in determining that individual's retirement benefits.

Sec. 101(b)(1) amends Sec. 332 of the Public Health Service Act to establish a new system for designating health manpower shortage areas. Under this system, the Secretary would refer a notice of proposed designation (including a proposed revision of an existing designation) to each health systems agency for a health service area which includes the proposed health manpower shortage area. If there is no designated health systems agency, the referral would be to the State health planning and development agency. Each health systems agency would have a reasonable period of time to review the proposal. In their review, the health systems agency would be required to consider criteria established under Section 332(b) of the Public Health Service Act, the comments of all interested persons and the appropriate health professions societies (which would have 90 days to provide written comment), and other matters. The health systems agency would approve or disapprove the designation and submit a detailed statement of its reasons to the Secretary. The secretary would then act in accord with the agency's decision, unless, within 60 days, she determined the decision was not supported by the criteria and other matters and submitted to the agency a detailed statement of the reasons for her determination. This new system would go into effect one year after the date of enactment of this measure.

Sec. 101(b)(2) amends Sec. 333 of the Public Health Service Act: (1) to require the Secretary, at least 90 days before approving an application for assignment of National Health Service Corps personnel to an area, to give appropriate health professions societies in that area opportunity to submit written comments on such assignment; and (2) to require that each health systems agency and State health planning and development agency consider these written comments in their review of applications for the assignment of National Health Service Corps personnel.

Sec. 101(c) amends Sec. 332(h) of the Public Health Service Act to require the Secretary to inform appropriate individuals and entities in health manpower shortage areas who may be interested in the availability of health professions personnel, of the provisions of the Public Health Service Act which allow an individual to satisfy a National Health Service Corps scholarship obligation through the private practice of what individual's profession.

Sec. 101(d)(1) amends Sec. 333(a) of the Public Health Service Act to require the Secretary not to discriminate against entities which receive no other Federal assistance under the Public Health Service Act, but which apply for the assignment of National Health Service Corps members.

Sec. 101(d)(2) amends Sec. 333 of the Public Health Service Act to require that the Secretary not approve an application from an entity for the assignment of a member of the National Health Service Corps who is not an employee of the United States, unless that entity assures the Secretary that it: (A) has sufficient financial resources to

provide that member of the Corps with an income which is not less than that which the person would receive as a civilian employee of the United States appointed to the Corps, or (B) would have sufficient financial resources if it received supplemental grant support. This section also authorizes the Secretary to make such a supplemental grant award to assist an entity in meeting the salary requirements of a member of the Corps assigned to it, if the Secretary determines that the entity does not have sufficient financial resources to provide the required income for that member of the Corps.

Sec. 101(d)(3) amends Sec. 333 of the Public Health Service Act to require the Secretary to provide technical assistance to entities in health manpower shortage areas desiring to apply for assignment of National Health Service Corps personnel in (a) analyzing the potential use of such health professions personnel by the residents of such areas; (b) determining the need for such personnel; (c) determining the available financial base to support the practice of such personnel; and (d) determining the types of inpatient and other health services that should be provided by such personnel.

Sec. 101(d)(4) amends Sec. 333 of the Public Health Service Act to require the Secretary to conduct programs to demonstrate improvements that can be made in the assignment of members of the Corps to health manpower shortage areas and in the delivery of health care by Corps members in such areas through coordination with State and local governments and other qualified entities with expertise in planning, developing, and operating primary health care centers. Such demonstrations will include programs in which the Secretary enters into agreement with a qualified entity under which the Secretary will assign members of the Corps to primary care entities in appropriate health manpower shortage areas, if the qualified entity places in effect a program for the planning, development, and operation of primary care centers in such areas. As a prerequisite to participation in such demonstration programs, the Secretary must determine that the State or other qualified entity is able (i) to analyze potential use of health professions personnel by the residents of potential service area; (ii) to determine the need for such personnel and have the capacity to recruit, select, and retain such personnel to meet that need; (iii) to determine the presence of and need for additional sources of financial support for such personnel; (iv) to determine the types of inpatient and other health services that should be provided by such personnel; (v) to assist such personnel in the development and management of their practice; (vi) to assist in planning and development of needed primary health care facilities; and (vii) to assist in establishing any required primary health care center governing body and to assist such body in defining and carrying out its responsibilities.

Sec. 101(e)(1) through (e)(3) provide correcting amendments to Sec. 334(a) of the Public Health Service Act to properly describe cost sharing procedures for entities to which members of the National Health Service Corps who are not employees of the United States are assigned.

Sec. 101(e)(4) amends Sec. 334(b) of the Public Health Service Act to require that the Secretary not discriminate against public en-

tities in application of the waiver provisions of the cost-sharing requirements associated with a National Health Service Corps assignee.

Sec. 101(e)(5) amends Sec. 334(e) of the Public Health Act to: (1) establish a revolving fund, to be called the National Health Service Corps Fund, in the Treasury of the United States; (2) provide for deposits to the Fund under the cost sharing provisions of the National Health Service Corps program; (3) authorize deposit and investment of funds in the Fund by the Secretary of Health and Human Services with the approval of the Secretary of the Treasury; (4) authorize the Secretary of Health and Human Services, without fiscal year limitation, to use funds in this Fund to carry out the purposes of the National Health Service Corps program; and (5) specifically exempt the Fund and funds credited to it from apportionment for any other purpose.

Sec. 101(f)(1) amends Subpart II of Part D of Title III of the Public Health Service Act (National Health Service Corps program) by transferring Section 755 of the Public Health Service Act (special grants for former Corps members to enter private practice) to that subpart, and by adding a new section, to be designated "Preparation for Practice", to that subpart. Under that new section, the Secretary is authorized to make grants and enter into contracts with public and private non-profit entities to conduct programs to prepare individuals with a service obligation to the National Health Service Corps to effectively provide health services in the health manpower shortage areas to which they are assigned.

Sec. 101(f)(2) amends Sec. 755(a)(1) of the Public Health Service Act to make an individual who has completed at least two years of his obligated service in the Corps, and who agrees to engage in private full-time clinical practice in a health manpower shortage area, eligible to receive grant support under that section (not to exceed $25,000) to asist in meeting the costs of initiating such practice.

Sec. 101(g) amends Sec. 338(a) of the Public Health Service Act to provide authorizations of appropriations for the National Health Service Corps program of $94 million for fiscal year 1981, $145 million for fiscal year 1982, and $205 million for fiscal year 1983.

Sec. 101(h) requires the Secretary to report to the Congress within 18 months the results of a study designed: (a) to evaluate the criteria currently used to determine if an area is a health manpower shortage area; (b) to see if any areas which are not truly health manpower shortage areas may have been so designated using existing criteria; and (c) to consider different criteria which might be used to designate health manpower shortage areas.

REVISION AND EXTENSION OF A NATIONAL HEALTH SERVICE CORPS SCHOLARSHIP PROGRAM

Sec. 102(a)(1) amends Sec. 752(b) of the Public Health Seervice Act to require the Secretary to determine, not later than 90 days before an individual is to begin fulfilling his National Health Service Corps scholarship obligated service, whether that individual shall provide such service as an employee of the United States or as a member of the Corps who is not an employee of the United States. If the

Secretary determines that the individual shall provide obligated service as a member of the Corps who is not an employee of the United States, the Secretary shall designated such individual as a member of the Corps to provide such service.

Sec. 102(a)(2)(A) provides a conforming amendment to Sec. 752 of the Public Health Service Act (obligated service) to include as designated members of the Corps those individuals who are fulfilling a National Health Service Corps scholarship obligation but who are not employees of the United States.

Sec. 102(a)(2)(B) amends Sec. 752(d) of the Public Health Service Act to include only individuals who are employees of the United States among those whom the Secretary may detail to other units of the Department to fulfill their periods of obligated service.

Sec. 102(b) amends Sec. 752(e) of the Public Health Service Act to require that the duration of service of an individual receiving a National Research Service Award (as provided for under Sec. 472 of the Public Health Service Act) be counted against that individual's National Health Service Corps scholarship obligated service time.

Sec. 102(c)(1) amends Sec. 753(b)(1)(B) of the Public Health Service Act to require any National Health Service Act to require any National Health Service Corps scholarship recipient who is fulfilling his service obligation in private practice in a health manpower shortage area to accept assignment under the Medicare program and to have an agreement with the appropriate State Agency to provide services to Medicaid eligible individuals.

Sec. 102(c)(2) amends Sec. 753 of the Public Health Service Act by adding two new provisions that: (1) authorize the Secretary to permit any individual who breachs his National Health Service Corps scholarship contract by failing to begin or to complete his scholarship service obligation, to fulfill such obligation as a member of the Corps; and (2) require the Secretary, upon request, to provide technical assistance, in establishing a clinical practice, to those individuals wishing to fulfill their National Health Service Corps scholarship obligation in private practice in a health manpower shortage area.

Sec. 102(c)(3) amends Sec. 751(c)(2) of the Public Health Service Act to require the Secretary to provide information to potential National Health Service Corps scholarship recipients concerning possible fulfillment of any future service obligation through private practice in a health manpower shortage area.

Sec. 102(c)(4)(A) amends Sec. 753(a) of the Public Health Service Act (private practice): (1) to clarify that an individual who received a scholarship under Sec. 225 of the Public Health Service Act (a predecessor Federal scholarship program to the National Health Service Corps scholarship program) is eligible for the private practice option under Sec. 753; and (2) to delete the requirement that a health manpower shortage area meet the following conditions prior to assigning a member of the Corps to that area for private practice; (a) priority for assignment of a Corps member, and (b) sufficient financial base to sustain a private practice and provide an individual an income not less than the income of members of the Corps.

Sec. 102(c)(4)(B) amends Sec. 754(c) of the Public Health Service Act to clarify that existing repayment requirements applying to an

individual who received scholarship assistance under Sec. 225 of the Public Health Service Act (a predecessor Federal scholarship program to the National Health Service Corps scholarship program) are not altered by virtue of that individual electing the private practice option.

Sec. 102(c)(4)(C) provides a technical conforming amendment to Sec. 735(c)(1) of the Public Health Service Act.

Sec. 102(d) amends Sec. 751(a) of the Public Health Service Act to include clinical psychologists among those health professions eligible to participate in the National Health Service Corps scholarship program if the Secretary determines such health professionals are needed by the Corps.

Sec. 102(e) amends Sec. 751(d) of the Public Health Service Act to require the Secretary, when reviewing National Health Service Corps scholarship applications, to give special consideration to applications of individuals who intend to be primary care physicians in health manpower shortage areas, who have resided or been employed in such areas, or who meet such other qualifications as the Secretary may prescribe to assist in determining if an individual will become a primary care physician in such an area.

Sec. 102(f) amends Sec. 756(a) of the Public Health Service Act to provide authorizations of appropriations for the National Health Service Corps scholarship program of $92 million for fiscal year 1981; $101 million for fiscal year 1982; and $109 million for fiscal year 1983. In addition, provision is included to make continued scholarship awards available for fiscal years 1984 and 1985 to students who enter into written contracts with the scholarship program before October 1, 1983.

Sec. 102(g) provides an effective date for the provisions of Sec. 102(a) which is the date of enactment of the Act. This section further provides that any individual who has entered into a National Health Service Corps scholarship contract prior to the date of enactment of this Act, but who has not yet begun the period of obligated service required under that contract, shall be given the opportunity to revise that contract to permit that individual to serve such period as a member of the Corps who is not an employee of the United States.

TITLE II—HEALTH PROFESSIONS PROGRAMS UNDER TITLE VII

PART A—CONSTRUCTION ASSISTANCE

Sec. 201 amends Sec. 721(c) of the Public Health Service Act by repealing the enrollment increase requirement in the existing construction grant program for the health professions educational institutions, and by applying the provisions of that amendment to entities which received such grants prior to the date of enactment of this Act.

Sec. 202(a) amends Sec. 720(a) of the Public Health Service Act to authorize the Secretary to make grants to schools providing the first two years of medical education to assist in the construction of teaching facilities which such schools may require to become four year schools of medicine.

Sec. 202(b) amends Sec. 720(b) of the Public Health Service Act to provide an authorization of $15 million for construction grants to two-

year schools of medicine for fiscal year 1981, to remain available until expended.

Sec. 202(c) amends Sec. 721(b)(1) of the Public Health Service Act to require that an applicant for construction grant funds authorized by this section be an accredited public or nonprofit school providing the first two years of education leading to the degree of doctor of medicine.

Sec. 202(d) provides a technical conforming amendment to Sec. 721(g) of the Public Health Service Act.

Sec. 202(e) amends Sec. 722(a) of the Public Health Service Act to provide that the amount of construction grants authorized by this section shall be determined by the Secretary but may not exceed 80 percent of total project costs.

Sec. 202(f) provides a technical conforming amendment to Sec. 720(a) of the Public Health Service Act.

Sec. 203(a) amends Sec. 726(a) of the Public Health Service Act to provide loan guarantees only for projects for the remodeling, renovation, or alteration of health professions teaching facilities (rather than new construction) through fiscal year 1983.

Sec. 203(b) amends Sec. 726(b) of the Public Health Service Act to permit the Secretary to make all authorized interest subsidy payments on any loan made under and in accord with the terms of this section prior to October 1, 1980.

PART B—STUDENT ASSISTANCE EXTENSION AND REVISION OF INSURED LOAN PROGRAM

Sec. 205(a) amends Sec. 728(a) of the Public Health Service Act (relating to the Federal program of insured loans to graduate students in health professions schools) by continuing at $520 million for each of the next three fiscal years the ceiling on the total principal amount of new loans made and installments paid pursuant to lines of credit to borrowers covered by Federal loan insurance under this program. Provision is also made that no insurance may be granted for any loan made or installment paid after September 30, 1985.

Sec. 205(b) amends Sec. 729(a) of the Public Health Service Act to increase the maximum allowable borrowing limits under the Federal program of insured loans to graduate students in schools of medicine, osteopathy, or dentistry to $20,000 per year with an aggregate maximum of $80,000 over four years.

Sec. 205(c)(1) amends Sec. 731(a)(1)(A) of the Public Health Service Act by repealing the current prohibition on the receipt of funds under this insured student loan program and any program provided or assisted under Part B of Title IV of the Higher Education Act of 1965 during the same school year.

Sec. 205(c)(2) amends Sec. 731(a)(2) of the Public Health Service Act to allow a deferral of payment on the principal and interest on the loan (currently only a deferral on the principal is authorized) during specified periods of education, training, and public service.

Sec. 205(c)(3) amends Sec. 731(a)(2) of the Public Health Service Act to require the lender to offer, in accordance with criteria prescribed by the Secretary, a schedule for repayment of principal and interest under which a portion of the principal and interest otherwise

payable at the beginning of the repayment period is deferred until a later time.

Sec. 205(c)(4) amends Sec. 731(c) of the Public Health Service Act with a technical conforming amendment.

Sec. 205(d) amends Sec. 731(b) to provide that the maximum rate of interest prescribed by the Secretary for the Federal program of insured loans to graduate students in health professions schools may not exceed the average of the bond equivalent rates of the 91-day Treasury bills auctioned for the previous quarter plus 2 percent.

Sec. 205(e) amends Sec. 737 of the Public Health Service Act to delete the current requirement that only those institutions receiving capitation grant support (or eligible to receive such support) are to be eligible to participate in the Federal program of insured loans to graduate students in the health professions.

Sec. 205(f) amends Sec. 739(b) of the Public Health Service Act by repealing the current requirement that no more than 50 percent of the students in each class in schools of medicine, osteopathy, or dentistry may have loans insured under this program.

EXTENSION OF STUDENT LOAN PROGRAM

Sec. 206 amends sections 742 and 743 of the Public Health Service Act (relating to student loans) to provide authorizations of appropriations of $20 million for fiscal year 1981; $22.5 million for fiscal year 1982 and $25 million for fiscal year 1983 for the health professions student loan program, and such sums as may be necessary through fiscal year 1986 to enable students who received loans prior to October 1, 1983, to continue or complete their education.

EXTENSION OF SCHOLARSHIPS FOR STUDENTS OF EXCEPTIONAL FINANCIAL NEED

Sec. 207 amends Sec. 758(d) of the Public Health Service Act (scholarships for first year students of exceptional financial need) by: (1) authorizing appropriations of $30 million for fiscal year 1981; $40 million for fiscal year 1982; and $50 million for fiscal year 1983; (2) making such scholarships available for both the first and second years of graduate study; and (3) repealing the requirement that grants under this section shall be made to all schools of the health professions.

PART C—INSTITUTIONAL SUPPORT

Sec. 211 amends Sec. 770 of the Public Health Service Act (capitation grants) by replacing existing programs of capitation grants with a program of institutional support. The program of institutional support authorized by this section is to provide assistance for the educational programs of schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, pharmacy, and podiatry. The amount of the annual award to any institution is to be an amount equal to the product of that institution's enrollment and the specified dollar amount provided for that type of health professions institution for that fiscal year. Provision is made for pro rata reductions in grant

awards should appropriations be insufficient to meet formula requirements. Regulations of the Secretary are to be followed in determining enrollment in each eligible institution; however, in pharmacy programs with a course of study exceeding four years, only students in the last four years are to be counted, and in schools of medicine, osteopathy, or dentistry offering a doctoral degree within six years of completing secondary school, only students in the last four years shall be counted.

This section also authorizes the following appropriations (by health profession) for fiscal years 1981, 1982, and 1983, respectively: (1) schools of medicine—$37.259 million; $24.836 million; and $12.418 million; (2) schools of osteopathy—$2.904 million; $1.936 million; and $.968 million; (3) schools of dentistry—$12.148 million; $8.099 million; and $4.049 million; (4) schools of veterinary medicine—$2.7 million; $1.8 million; and $.9 million; (5) schools of optometry—$.794 million; $.529 million; and $.265 million; (6) schools of pharmacy—$4.538 million; $3.025 million; and $1.513 million; schools of podiatry—$.609 million; $.406 million; and $.203 million.

Sec. 212(a)(1) amends Section 771(a)(1) of the Public Health Service Act to allow the Secretary to disregard enrollment increases in schools of medicine, made by such schools to enable them to qualify for a special assistance program of the Veterans' Administration, in assessing such schools' maintenance of enrollment efforts to determine eligibility for the awarding of capitation grants in fiscal year 1980.

Sec. 212(a)(2) amends Sec. 771(a) of the Public Health Service Act to provide grant requirements which must be met before eligible schools can receive institutional support grants beginning in fiscal year 1981. These conditions include the submittal of an application which must contain assurances that the school will not reduce the amount of non-Federal funds used to support its operations from the amount expended in the preceding fiscal year.

In addition, provision is made that if in any future fiscal year the amount appropriated for institutional support grants for any category of schools is less than the amount appropriated for fiscal year 1980 for such schools, no school may receive institutional grant support in that fiscal year unless it received such support in fiscal year 1980.

Sec. 212(b) amends Sec. 771(b) of the Public Health Service Act to repeal a one-time enrollment increase requirement for schools of medicine which was in effect only for fiscal year 1978.

Sec. 212(c) amends Sec. 771(g)(3) of the Public Health Service Act (relating to requirements for institutional support grants for schools of optometry) to reduce from 50 percent to 25 percent the percent of first year students which private, nonprofit schools of optometry must enroll from States without accredited schools of optometry to be eligible for such institutional grant support.

Sections 212(d) through (f) provide technical correcting and conforming amendments to section 771, 772, and 788 of the Public Health Service Act.

PART D—PROJECT GRANTS AND CONTRACTS

Sec. 215(a) amends Sec. 780(c) of the Public Health Service Act to continue to provide authorizations of appropriations for project grants for departments of family medicine of $15 million for fiscal year 1981; $20 million for fiscal year 1982; and $25 million for 1983.

Sec. 215(b) amends 780(b)(1)(D) of the Public Health Service Act to require as a condition of eligibility for project grant support for departments of family medicine, that the applicant have control over or affiliation with an approved residency training program in family medicine or its equivalent.

Sec. 216(a) amends Sec. 781(g) of the Public Health Service Act to continue to provide authorizations of appropriations for Area Health Education Centers of $21 million for fiscal year 1981; $28 million for fiscal year; and $30 million for 1983.

Sec. 216(b) amends Sec. 781(c) of the Public Health Service Act to provide that if one medical or osteopathic school participating in an Area Health Education Center program offers no less than 10 percent of all its undergraduate education in an area health education center or at locations under the sponsorship of such center, other participating schools need not meet that requirement.

Sec. 216(c) amends Sec. 781(d)(2)(E) of the Public Health Service Act by providing clarifying language to existing statute that one of the functions of an Area Health Education Center is to provide continuing medical educational and other educational support services to National Health Service Corps members serving within the area served by the Center.

Sec. 216(d) amends Sec. 781 of the Public Health Service Act to authorize the Secretary to enter into contracts with area health education centers having completed their initial period of eligibility for Federal assistance, to continue significant projects or to initiate new projects designed to improve health manpower distribution. No more than 10 percent of the total amount appropriated in any fiscal year for the area health education center program may be obligated for such contracts.

Sec. 216(e) provides that the contracting authority of the Public Health Service for programs of Area Health Education Centers is not authority to enter into cooperative agreements for such centers.

Sec. 217 amends Sec. 783 of the Public Health Service Act (relating to programs for physician assistants, expanded function dental auxiliaries, and dental team practice) by providing a technical correcting amendment of section designation, and by providing authorizations of appropriations for programs supported under this section of $14 million for fiscal year 1981; $15 million for 1982 and $16 million for 1983.

Sec. 218(a) amends Sec. 784(b) of the Public Health Service Act (relating to grants for training, traineeships, and fellowships in general internal medicine and general pediatrics) to provide authorizations of appropriations for such programs of $23 million for fiscal year 1981; $30 million for fiscal year 1982; and $32 million for fiscal year 1983.

Sec. 218(b) amends Sec. 784(a) of the Public Health Service Act (relating to grants for training, traineeships, and fellowships in gen-

eral internal medicine and general pediatrics) by: (1) including public and private nonprofit hospitals and other public and private nonprofit entities among those eligible to apply for such grants, and (2) including the training of physicians who plan to teach general internal medicine or pediatrics, and traineeship or fellowship support for such individuals among the areas eligible for program support under this section.

Sec. 219(a) amends Sec. 786(d) of the Public Health Service Act (relating to support for family medicine and general practice of dentistry) to provide authorizations of appropriations for such programs of $50 million for fiscal year 1981; $75 million for fiscal year 1982; and $80 million for fiscal year 1983.

Sec. 219(b) directs the Secretary, not later than one year after the date of enactment of this Act, to report to Congress the results and legislative recommendations stemming from a study mandated by this section to determine the most effective and efficient means of providing financial support to graduate medical education programs in medicine, pediatrics, and family medicine.

Sec. 220 amends Sec. 787 of the Public Health Service Act (relating to educational assistance to individuals from disadvantaged backgrounds) to: (1) expand the scope of program activities which may be supported under this section by authorizing the use of funds to (a) establish secondary education programs to encourage disadvantaged students to pursue health careers; (b) strengthen the preprofessional curriculum of Baccalaureate institutions attended by the disadvantaged; (c) establish joint programs between baccalaureate and health professions institutions; (d) provide remedial programs (including necessary traineeship support) prior to entering health professions schools; (e) identify and recruit disadvantaged students to health professions schools; (f) provide counseling work-study opportunities in health service agencies, and other services to enable disadvantaged students to complete their educations; (g) publicize existing sources of financial aid to disadvantaged students; and (h) increase the number of faculty from disadvantaged backgrounds in health professions institutions; (2) include schools of nursing among those institutions eligible to receive assistance under this section; (3) require that not less than 80 percent of the funds appropriated in any fiscal year under this section be obligated for grants or contracts to institutions of higher education and that no more than 5 percent be obligated for purposes of publicizing the availability of existing sources of financial aid; and (4) provide authorizations of appropriations for such programs of $30 million for fiscal year 1981, $33 million for fiscal year 1982, and $36 million for fiscal year 1983.

Sec. 221(a) amends Sec. 788(a)(1) of the Public Health Service Act (relating to project grant authority for start-up assistance) by repealing such authority for new schools of medicine, osteopathy, and dentistry. This section does provide, however, that any such institution which received a grant under this authority for fiscal year 1980, may continue to receive grants in accordance with the legislative provisions in effect for that fiscal year.

Sec. 221(b) amends Sec. 788(c) of the Public Health Service Act to authorize the Secretary to make grants to schools providing the first

two years of education leading to the degree of doctor of medicine to assist such schools in accelerating the date by which they will become four year schools of medicine. The amount of such grants shall be the product of $25,000 and the number of full time third year students estimated to be enrolled in the school year beginning in the fiscal year in which the grant is made.

Sec. 221(c) amends Sec. 788(d) of the Public Health Service Act to include "training of health professionals in the diagnosis, treatment, and prevention of diabetes and other severe chronic diseases and their complications" among those projects which are eligible for support under that section.

Sec. 221(d) amends Sec. 788(d)(6) of the Public Health Service Act to include schools of dentistry among those health professionals institutions eligible to receive curriculum development support under that section.

Sec. 221(e) amends Sec. 788(e)(1) of the Public Health Act (relating to startup, financial distress, interdisciplinary training, and curriculum development grants) by providing authorizations of appropriations of $10 million for fiscal year 1981; $12.5 million for 1982; and $15 million for 1983.

Sec. 221(f) amends Part G of Title VII of the Public Health Act to add a new Section 789A, Financial Distress Grants.

Under new Section 789A, the Secretary is authorized to make grants to schools of medicine, osteopathy, dentistry, public health, veterinary medicine, optometry, pharmacy, and podiatry which are in serious financial distress. Such grants may be used to assist in (a) meeting the costs of operation of the school; (b) meeting any special accreditation requirements of the school; (c) carrying out needed operational, managerial and financial reforms; (d) maintaining the quality of education programs; or (e) strengthening academic resources and capabilities. The Secretary may determine such terms and conditions as are reasonable and necessary in awarding such grants, and may specify the period of time for which the grant shall be made. The Secretary may also provide technical assistance to enable the school to conduct a comprehensive cost analysis study of its operations.

The recipient of such a grant must provide assurances that it will not reduce its share of non-Federal expenditures from an amount equal to the average amount of such funds expended in the two years preceding the year in which the grant is awarded.

Authorizations of appropriations of $20 million for fiscal year 1981, $20 million for fiscal year 1982, and $20 million for fiscal year 1983 are provided for such financial distress grants. Funds appropriated under this section are to remain available until expended.

Sec. 221(g) amends Sec. 788 of the Public Health Service Act by repealing authority to support: (1) programs of cooperative interdisciplinary training; (2) the costs attendant to the development of new schools of medicine; and (3) the costs of training medical students in facilities which are not the principal teaching facilities of the medical school and which are located in health manpower shortage areas.

PART E—PUBLIC HEALTH PERSONNEL

Sec. 230 amends Subpart I of Part G of Title VII of the Public Health Service Act (public health personnel) by recodifying existing programs of support for public health and by authorizing new programs of support for public health in the following manner:

New section number	Comparable old section number	Program authority
791	771(e)	Institutional support.
792	748	Public health traineeships.
793	792	Public health special projects.
794		Midcareer training and education.
794A	791	Graduate programs in health administration.
794B	749	Graduate health administration traineeships.
794C		Departments of preventive or community medicine or dentistry.
794D		Training in preventive medicine.
794E		Curricula development projects for graduate programs in health administration.
794F		Faculty development programs.
794G	793	Statisics and annual report.

Sec. 230(1) amends Subpart I of Part G of Title VII of the Public Health Service Act by inserting at the beginning of that subpart a new section 791 entitled "Institutional Support." The authority of award such grants, specific grant requirements including application requirements, and the methods to be used in making enrollment determinations for the purpose of awarding institutional support grants conform to existing requirements for capitation grants to schools of public health. The amount of a grant to any individual institution is to be an amount which bears the same ratio to the total amount appropriated for such purpose as the enrollment of that institution bears to the total enrollment of all eligible institutions. For purposes of making institutional support grants to schools of public health, this section authorizes appropriations of $7 million for fiscal year 1981, $8 million for fiscal year 1982, and $9 million for fiscal year 1983.

Sec. 230(2) amends the Public Health Service Act by transferring and redesignating section 748 (public health traineeships) as section 792 of the Public Health Service Act, by substituting baccalaureate degree requirements for existing postbaccalaureate degree requirements pertaining to such traineeship support, and by authorizing appropriations for such purpose of $8 million for fiscal year 1981; $9 million for fiscal year 1982; and $10 million for fiscal year 1983.

Sec. 230(3) amends the Public Health Service Act by transferring and redesignating section 792 (special projects for accredited schools of public health and graduate programs in health administration) as section 793 of the Public Health Service Act, by renaming that section, "Special Projects for Accredited Schools of Public Health," and by authorizing appropriations for such programs of $5 million for fiscal year 1981, $5.5 million for fiscal year 1982, and $6 million for fiscal year 1983.

Sec. 230(4) amends the Public Health Service Act by establishing a new section 794 entitled "Midcareer Training and Education." The new section 794 authorizes the Secretary to make grants and contract awards to public and nonprofit private entities for the establishment,

62-655 O - 80 - 9

operation, and administration of centers to provide intensives, short-term advanced training to individuals with demonstrated expertise in health policy and management in (i) health systems management, (ii) health policy, planning, and regulation, (iii) environmental policy and management, (iv) financial management and strategy in health care, (v) management of collaboration between health care entities, (vi) management of small health care entities in inner cities and rural areas, and (vii) similar matters to increase the capabilities of such individuals in carrying out their responsibilities. For the purposes of the section there are authorized to be appropriated $1.5 million for fiscal year 1981, $2.5 million for fiscal year 1982, and $3 million for fiscal year 1983.

Sec. 230(5) amends the Public Health Service Act by transferring and redesignating section 791 (grants for graduate programs in health administration) as section 794A of the Public Health Service Act, by increasing to $150,000 the amount of non-Federal support an applicant institution must commit to its program of health administration as a prerequisite to eligibility under this section, by defining nine program areas (including health planning, health policy, ambulatory care services, long-term care, home health care, multi-unit care systems, comprehensive prepaid service systems, mental health administration, and other health care systems determined by the Secretary to require special emphasis) one or more of which must be emphasized by a training program to be eligible for support under this section, and by authorizing appropriations for this purpose of $4 million for fiscal year 1981, $4.5 million for fiscal year 1982, and $5 million for fiscal year 1983.

Sec. 230(6) amends the Public Health Service Act by transferring and redesignating section 749 (traineeships for students in other graduate programs) as section 794B of the Public Health Service Act, by substituting baccalaureate degree requirements for existing postbaccalaureate degree requirements pertaining to such traineeship support, and by authorizing appropriations for such purpose of $2.5 million for fiscal year 1981, $3 million for fiscal year 1982, and $3.5 million for fiscal year 1983.

Sec. 230(7) amends the Public Health Service Act by establishing four new sections, 794C, 794D, 794E, and 794F, entitled "Grants to Departments of Preventive or Community Medicine or Dentistry," "Training in Preventive Medicine," "Special Curricula Development Projects for Graduate Programs in Health Administration," and "Faculty Development Programs," respectively.

The new section 794C authorizes the Secretary to make grants to schools of medicine, dentistry, and osteopathy to establish, maintain, and improve academic units in preventive or community medicine or dentistry; to improve instruction in such areas; to support joint programs between other clinical specialties and preventive or community medicine or dentistry; and to train teachers and researchers in preventive, community, or occupational medicine or denistry. For these purposes, this section authorizes appropriations of $2 million for fiscal year 1981, $3 million for fiscal year 1982, and $4 million for fiscal year 1983.

The new section 794D authorizes the Secretary to make grants to schools of medicine and schools of public health to plan, develop, and

expand residency training programs in preventive medicine, and to provide financial assistance to residency trainees in such programs. To be eligible to receive such a grant the institution must have available full time faculty members with training and experience in preventive medicine, and support from other faculty in public health and other relevant specialties and disciplines. For such purposes, this section authorizes appropriations of $6 million in fiscal year 1981, $7 million in fiscal year 1982, and $8 million in fiscal year 1983.

The new section 794E authorizes the Secretary to make grants to educational institutions with accredited programs in health administration to meet the costs of curriculum development in a wide range of health administration subject areas including finance; marketing; economics; epidemiology and health planning; health policy, law, and regulation; quality assurance and assesment; information systems; health services organization and management for sudents in health discipines other than health administration; and management of ambulatory care services. Authorizations of appropriations of $3, $4, and $5 million are provided for fiscal years 1981, 1982, and 1983 respectively.

The new section 794F authorizes the Secretary to make grants to accredited schools of public health and other educational institutions with accredited programs in health administration to establish and operate faculty development programs. One year fellowships provided by institutions under this section shall be limited to individuals who have received a doctoral degree (or equivalent) and who agree to serve at least two years as a faculty member in an accredited public health or health administration institution. Authorizations of appropriations of $1 million are provided for each of the fiscal years 1981, 1982, and 1983.

Sec. 230(8) amends the Public Health Service Act by transferring and redesignating section 793 (Statistics and Annual Report) as Section 794G of the Public Health Service Act.

Sec. 231. requires the Secretary: (1) to assess and dientify, on an ongoing basis, current and projected personnel needs for environmental and occupational health workers and such needs for the implementation of Federal, State, and local environmental protection and occupational health laws, and (2) to study and assess a variety of educational and service needs and governmental agency operations, making reports of such findings to the Congress.

An authorization of $1 million is provided for each of the next three fiscal years for these studies.

PART F—ALLIED HEALTH PERSONNEL

Sec. 235 amends section 796(d)(1) of the Public Health Service Act (relating to project grants for allied health) to provide authorizations of appropriations of $9 million for fiscal year 1981, $9.5 million for fiscal year 1982, and $10 million for fiscal year 1983.

Sec. 236 amends section 797(c) of the Public Health Service Act (relating to traineeships for allied health) to provide authorizations of appropriations of $1.3 million for fiscal year 1981, $1.4 million for fiscal year 1982, and $1.5 million for fiscal year 1983.

Sec. 237 amends section 798(c) of the Public Health Service Act (relating to assistance to disadvantaged individuals) to provide authorizations of $1 million for fiscal year 1981, $1 million for fiscal year 1982, and $1 million for fiscal year 1983.

Sec. 238 amends Sec. 795(2)(A), the definition of 'training center for allied health professions' by deleting specific reference to individual allied health professional curricula in that definition.

TITLE III—NURSE TRAINING

Construction

Sec. 301(a) amends sections 801 and 802 of the Public Health Service Act (relating to construction grants for schools of nursing) to provide authorizations of appropriations for grants for construction projects for schools of nursing in health manpower shortage areas of $1 million in fiscal year 1981, $1 million in fiscal year 1982, and $1 million in fiscal year 1983.

Sec. 301(b) amends section 805(a) of the Public Health Service Act (relating to loan guarantees and interest subsidies for construction projects at schools of nursing) to extend that program through September 30, 1983.

Institutional support

Sec. 302(a) amends section 810(a) of the Public Health Service Act (relating to capitation grants for schools of nursing) by: (1) redesignating that part as 'Institutional Support'; and (2) providing that collegiate, associate degree, and diploma schools of nursing shall each be eligible to receive institutional support amounting to the product of their enrollment (as defined) and $200 for fiscal year 1981, $210 for fiscal year 1982, and $220 for fiscal year 1983. For purposes of this section, the defined enrollment for a collegiate school is the number of full-time students and full-time equivalents of part-time students in each of the last two years of that school. For purposes of this section, for an associate degree or diploma school, the defined enrollment is the number of full-time students and the number of full-time equivalents of part-time students of that school.

Sec. 302(b) amends section 810(c)(2) of the Public Health Service Act (relating to requirements for institutional support) to condition receipts of an institutional support grant on meeting one of the following requirements:

(1) an increase in the first year enrollment of full-time students by 15 percent or 10 students, whichever is greater, of the previous year's first year enrollment;

(2) in the case of a collegiate school, carry out a program for the training of nurse practitioners;

(3) a program to identify, recruit, enroll, retain, and graduate individuals from disadvantaged backgrounds, under which at least 20 percent of each year's entering class (or 10 students, whichever is greater) is composed of such individuals;

(4) in the case of a collegiate school, at least 20 percent of each year's entering class of full-time students (or ten students, whichever is greater) is composed of individuals with an associate degree in nursing or a diploma from a diploma school of nursing;

(5) in the case of an associate degree school or diploma school of nursing, at least 20 percent of each year's entering class of full time students (or ten students, whichever is greater) is composed of individuals who are licensed practical, or vocational nurses; and

(6) the number of part-time students enrolled is at least 20 percent of all students enrolled.

Sec. 302(c) amends section 810(d) of the Public Health Service Act to define the method of calculation to be used in determining full time equivalents of part-time students in schools of nursing for the purpose of awarding institutional support grants.

Sec. 302(d) amends section 810(f) of the Public Health Service Act to provide authorizations of appropriations for institutional support grants for schools of nursing of $25 million for fiscal year 1981, $27.5 million for fiscal year 1982, and $30 million for fiscal year 1983.

Sec. 302(e) amends the heading of section 810 of the Public Health Service Act to read 'institutional support'.

Special projects

Sec. 303(a) amends section 820(a) of the Public Health Service Act (relating to special project grants and contracts) by repealing the following projects as eligible for funding under this section: (1) mergers or other cooperative arrangements between hospitals and other academic institutions; (2) programs of research in or curriculum improvement in nurse training education; and (3) development costs for short-term inservice training programs for nurses aides and orderlies in nursing homes. In addition, this section limits special projects to provide training and education to upgrade professional skills to licensed vocational or practical nurses.

Provision is also made that any entity which received a grant in fiscal year 1980, for any of the program authorities repealed by this section, may receive one additional grant or contract under such section.

Sec. 303(b) amends section 820(d) of the Public Health Service Act to provide authorizations of appropriations for special projects grants of $15 million for fiscal year 1981, $17.5 million for fiscal year 1981, and $20 million for fiscal year 1983. In addition, a requirement is added that not less than 20 percent of the funds appropriated for this purpose must be obligated for projects to increase nursing education opportunities for individuals from disadvantaged backgrounds, and not less than 20 percent of such funds must be obligated for projects to help increase the supply or improve the distribution by geographic area or by specialty group of trained nursing personnel to meet the health needs of the nation.

Advanced nurse training

Sec. 304 amends section 821 of the Public Health Service Act (advanced nurse training programs) by providing a technical correcting amendment and by authorizing appropriations for such programs of $12 million for fiscal year 1981, $13.5 million for fiscal year 1982 and $15 million for fiscal year 1983.

Nurse practitioner programs

Sec. 305(a) amends section 822(b)(1) of the Public Health Service Act: (1) by removing the requirement that a nurse practitioner traineeship recipient be a resident of a health manpower shortage area, and (2) by requiring the Secretary to give special consideration to applications for nurse practitioner traineeship programs which will train individuals who are residents of health manpower shortage areas.

Sec. 305(b)(1) amends section 822(b)(3) of the Public Health Service Act to require recipients of nurse practitioner traineeships to practice in a health manpower shortage area for a period of time equal to that for which their traineeship support was provided.

Sec. 305(b)(2) amends section 822(b) of the Public Health Service Act: (1) to require any individual who fails to complete a nurse practitioner traineeship service obligation, to pay to the United States an amount equal to the cost of tuition, other educational expenses, and other payments paid by the traineeship, plus interest at the maximum legal prevailing rate; (2) to require any such traineeship recipient who is dismissed or voluntarily terminates academic training, to repay to the United States an amount equal to any and all payments made to or on behalf of that individual under the traineeship; and (3) to give the Secretary waiver authority for these provisions if it is determined that compliance is impossible or would involve extreme hardship.

Sec. 305(b)(3) provides that the amendments made by sections 305(b)(1) and (2) shall apply only with respect to traineeships awarded after the date of enactment of this Act.

Sec. 305(c) amends section 822(e) of the Public Health Service Act to provide authorizations of appropriations for nurse practitioner programs of $17 million for fiscal year 1981, $18.5 million for fiscal year 1982 and $20 million for fiscal year 1983.

Traineeships

Sec. 306(a)(1) amends section 830(a)(1)(C) of the Public Health Service Act (traineeships for advanced training of professional nurses) to debate traineeship support for nurse practitioners under this section and to include nurse midwives among those areas of advanced training which may be supported.

Sec. 306(a)(2) provides that any individual who received a traineeship for training as a nurse practitioner under section 830(a) during fiscal year 1980, may continue to receive traineeships under that section to complete such training.

Sec. 306(b) amends section 830(b) of the Public Health Service Act to provide authorizations of appropriations for traineeships for advanced nurse training of $15 million for fiscal year 1981, $17.5 million for fiscal year 1982, and $20 million for fiscal year 1983.

In addition, provision is made that not less than 50 percent of the funds appropriated under this subsection shall be obligated for traineeships to train nurses to teach in the various fields of nurse training.

Nurse anesthetists

Sec. 307 amends section 831(b) of the Public Health Service Act (relating to nurse anesthetists programs) to provide authorizations of

appropriations of $2 million for fiscal year 1981, $3 million for fiscal year 1982, and $4 million for fiscal year 1983.

Student loans

Sec. 308(a) amends section 835(b)(4) of the Public Health Service Act by extending until October 1, 1983, the prohibition against simultaneous receipt of loans under this section and under section 204 of the National Defense Education Act of 1958.

Sec. 308(b) amends section 836(b) of the Public Health Service Act: (1) to require that new loan recipients under this section, after the date of enactment of this Act, be in exceptionally needy circumstances or from a low-income or disadvantaged family, and (2) to increase the rate of interest on the unpaid balance of such loans from 3 percent per annum to 6 percent per annum.

Sec. 308(c) amends section 837 of the Public Health Service Act to provide authorizations of appropriations for student loans of $15 million for fiscal year 1981; $17.5 million for fiscal year 1982; and $20 million for fiscal year 1983. In addition, authorization is provided for the appropriation of such sums as are necessary for each of the next three fiscal years to enable students who received a loan for any academic year ending before October 1, 1983, to continue or complete their education.

Sec. 308(d) amends section 839 of the Public Health Service Act to defer until 1986 the distribution of assets from loan funds established under section 835.

Scholarships

Sec. 309 amends Sec. 845 of the Public Health Service Act (scholarship grants) to extend existing authorities for scholarship grants to schools of nursing through fiscal year 1983.

Sec. 310 amends section 851(a) of the Public Health Service Act by deleting the Commissioner of Education as a member of the National Council on Nurse Training.

TITLE IV—GRADUATE MEDICAL EDUCATION

NATIONAL ADVISORY COMMITTEE

Sec. 401(a) amends Part A of Title VII of the Public Health Service Act by adding a new section 712, to be entitled 'Graduate Medical Education National Advisory Committee'.

The new section 712 establishes the Graduate Medical Education National Advisory Committee, defines its membership, the method of appointment of members and the chairperson, the term of office of members, the terms of compensation of members who are not officers or employees of the United States, the frequency with which the Advisory Committee shall meet, and provides for the delegation of support staff and administrative services to the Advisory Committee by the Secretary of Health and Human Services. In addition, the following functions of the Advisory Committee are prescribed:

(1) The Advisory Commitee shall—

(A) advise, consult with, and make recommendations to the Secretary with respect to—

(1) the need for and supply of physicians in the various medical specialties (including subspecialties) and with respect to the geographic distribution of physicians;

(2) the factors which affect a physician's choice of graduate medical training and the location of the physician's practice;

(3) the effect that—

(a) the rate of reimbursement for health care services provided by physicians in the different medical specialties; and

(b) the availability of financial support for persons undergoing graduate medical education,

have on the selection of a medical specialty or subspecialty;

(4) the proportion of health services provided by persons undergoing graduate medical education; and

(5) such other matters relating to graduate medical education as the Secretary may specify.

(B) recommend to the Secretary goals for (1) the distribution of physicians by medical specialties and subspecialties, and (2) the number of graduate medical education positions that should be available in each of the medical specialties and subspecialties; and

(C) recommend to the Secretary policies and procedures to achieve such goals.

Provision is made for consultation between the Advisory Committee and other appropriate entities including the coordinating Council on Medical Education, the Health Care Financing Administration and private health insurance carriers.

Finally, provision is made for current members of the Graduate Medical Education National Advisory Committee established by the Secretary of Health, Education and Welfare on May 1, 1978, to continue as members of the Advisory Committee for the prescribed term of office.

Changes in Existing Law Made by the Bill, as Reported

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman) :

Public Health Service Act

* * * * * * *

Subpart II—National Health Service Corps Program

NATIONAL HEALTH SERVICE CORPS

Sec. 331. (a) There is established, within the Service, the National Health Service Corps (hereinafter in this subpart referred to as the "Corps") which [(1) shall consist of such officers of the Regular and

Reserve Corps of the Service and such civilian personnel as the Secretary may designate (such officers and personnel hereinafter in this subpart referred to as "Corps members") and] *(1) shall consist*

(A) such officers of the Regular and Reserve Corps of the Service as the Secretary may designate,

(B) such civilian employees of the United States as the Secretary may appoint, and

(C) such other individuals who are not employees of the United States,

(such officers, employees, and individuals hereinafter in this subpart referred to as "Corps members"), and

* * * * * * *

(d)(1) The Secretary may, under regulations promulgated by the Secretary, adjust the monthly pay of each member of the Corps *(other than a member described in subsection (a)(1)(C))* who is directly engaged in the delivery of health services in a health manpower shortage area as follows:

(A) During the first 36 months in which such a member is so engaged in the delivery of health services, his monthly pay shall be increased by an amount (not to exceed $1,000) which when added to the member's monthly pay and allowances will provide a monthly income competitive with the average monthly income from a practice of an individual who is a member of the profession of the Corps member, who has equivalent training, and who has been in practice for a period equivalent to the period during which the Corps member has been in practice.

(B) During the period beginning upon the expiration of the 36 months referred to in subparagraph (A) and ending with the month in which the member's monthly pay and allowances are equal to or exceed the monthly income he received for the last of such 36 months, the member shall receive in addition to his monthly pay and allowances an amount which when added to such monthly pay and allowances equals the monthly income he received for such last month.

(C) For each month in which a member is directly engaged in the delivery of health services in a health manpower shortage area in accordance with an agreement with the Secretary entered into under section 741(f)(1)(C), under which the Secretary is obligated to make payments in accordance with section 741(f)(2), the amount of any monthly increase under subparagraph (A) or (B) with respect to such member shall be decreased by an amount equal to one-twelfth of the amount which the Secretary is obligated to pay upon the completion of the year of practice in which such month occurs.

For purposes of subparagraphs (A) and (B), the term "monthly pay" includes special pay received under chapter 5 of title 37 of the United States Code.

* * * * * * *

(3) A member of the Corps described in subparagraph (C) of subsection (a)(1) shall when assigned to an entity under section 333 be

subject to the personnel system of such entity, except that such member shall be entitled to receive during the period of assignment the income that the member would be entitled to receive if the member was a member of the Corps described in subparagraph (B) of such subsection.

* * * * * * *

(g) (1) The Secretary shall, by rule, prescribe conversion provisions applicable to any individual who, within a year after completion of service as a member of the Corps described in subsection (a) (1) (C), becomes a commissioned officer in the Regular or Reserve Corps of the Service.

(2) The rules prescribed under paragraph (1) shall provide that in applying the appropriate provisions of this Act which relate to retirement, any individual who becomes such an officer shall be entitled to have credit for any period of service as a member of the Corps described in subsection (a) (1) (C).

[(g)] *(h)* The administrative unit which administers section 770—

(1) shall participate in the development of regulations, guidelines, funding priorities, and application forms, and

(2) shall be consulted by, and may make recommendations to, the Secretary in the review of applications and proposals for, and the awarding of, grants and contracts,

with respect to the Corps.

[(h)] *(i)* For the purposes of this subpart:

(1) The term "Department" means the Department of Health [, Education, and Welfare.] *and Human Services.*

(2) The term "Scholarship Program" means the National Health Service Corps Scholarship Program established under section 751.

(3) The term "State" includes, in addition to the several States, only the District of Columbia, the Commonwealth of Puerto Rico, the Northern Mariana Islands, the Virgin Islands, Guam, American Samoa, and the Trust Territory of the Pacific Islands.

DESIGNATION OF HEALTH MANPOWER SHORTAGE AREAS

SEC. 332. (a) (1) For purposes of this subpart the term "health manpower shortage area" means (A) an area in an urban or rural area (which need not conform to the geographic boundaries of a political subdvision and which is a rational area for the delivery of health services) which [the Secretary determines] has a health manpower shortage, (B) a population group which [the Secretary determines] *as determined under this section* has a shortage, or (C) a public or nonprofit private medical facility or other public facility which [the Secretary determines] *as determined under this section* has such a shortage.

[(c) In determining whether to make a designation, the Secretary shall take into consideration the following:

[(1) (A) The recommendations of each health systems agency (designated under section 1515) for a health service area which includes all or any part of the area, population group, medical

facility, or other public facility under consideration for designation.

[(B) The recommendations of the State health planning and development agency (designated under section 1521) if such area, population group, medical facility, or other public facility is within a health service area for which no health systems agency has been designated.

[(2) The recommendations of the Governor of each State in which the area, population group, medical facility, or other public facility under consideration for designation is in whole or part located.

[(3) The extent to which individuals who are (A) residents of the area, members of the population group, or patients in the medical facility or other public facility under consideration for designation, and (B) entitled to have payment made for medical services under title XVIII or XIX of the Social Security Act, cannot obtain such services because of suspension of physicians from the programs under such titles.]

(c)(1) The Secretary shall refer a proposed designation of an area, population group, or facility (other than a Federal medical facility) to each health systems agency for a health service area which includes such area, group, or facility or if such an area, group, or facility is in a health service area for which a health systems agency has not been designated, to the State health planning and development agency for the State in which the area, group, or facility is located. Each health systems agency and State health planning and development agency to which a proposed designation has been referred shall be given a reasonable period to review the designation and approve or disapprove the designation. In making such a review the agency shall consider—

(A) the criteria established under subsection (b),

(B) the recommendation of the Governor of each State in which the area, population, or facility under consideration for designation is in whole or part located,

(C) the comments of all interested persons and the comments of the appropriate health professions societies in such area or whose members serve such population or facility, and

(D) the extent to which individuals who are (i) residents of the area, members of the population group, or patients in the facility, and (ii) entitled to have payments made for medical services under title XVIII or XIX of the Social Security Act, cannot obtain such services because of suspension of physicians from the programs under such titles.

The reviewing agency shall give written notice to health professions societies described in subparagraph (C) of the review of a proposed designation, and the societies shall be permitted to submit their comments on a proposed designation to the reviewing agency during the 90-day period beginning on the date the agency notifies it of the review of the proposed designation.

(2) Upon completion of its review of a proposed designation, the reviewing agency shall approve or disapprove the designation and submit to the Secretary a detailed statement in writing of the reasons for its decision. If an agency approves a proposed designation, the

Secretary shall, within the sixty-day period beginning on the date the Secretary receives the decision of the agency, make the designation unless the Secretary, within such period, determines the decision of the agency is not supported by the criteria established under subsection (b) and the other matters considered by the agency in making its decision and submits to the agency a detailed statement of the reasons for such determination. If an agency disapproves a proposed designation, the Secretary may not make the designation unless the Secretary, within the sixty-day period beginning on the date the Secretary receives the decision of the agency, determines the decision of the agency is not supported by the criteria established under subsection (b) and the other matters considered by the agency in making its decision and submits to the agency a detailed statement of the reasons for such determination.

(d) In accordance with the criteria established under subsection (b) and the considerations listed in subsection (c), the Secretary shall designate, not later than November 1, 1977, health manpower shortage areas in the States, publish a descriptive list of the areas, population groups, medical facilities, and other public facilities so designated, and at least annually review and, as necessary, revise such designations. *The revision of a designation shall be subject to the same review and approval and disapproval by health systems agencies and State health planning and development agencies as is prescribed by subsection (c) for designations.*

* * * * * * *

(g) Any person may recommend to the Secretary the designation of an area, population group, medical facility, or other public facility as a health manpower shortage area *or the revision of a health manpower shortage area.*

(h) The Secretary shall conduct such information programs in areas, among population groups, and in medical facilities and other public facilities designated under this section as health manpower shortage areas as may be necessary *(1)* to inform public and nonprofit private entities which are located or have a demonstrated interest in such areas of the assistance available under this title by virtue of the designation of such area, *and (2) to inform such entities and other individuals and entities who may be interested in the availability of health professions personnel of the provisions of section 753 which allow an individual to satisfy a National Health Service Corps Scholarship Program service obligation through the private practice of the individual's health profession.*

ASSIGNMENT OF CORPS PERSONNEL

SEC. 333. (a) (1) * * *

* * * * * * *

(3) In approving applications for assignment of members of the Corps the Secretary shall not discriminate against applications from entities which are not receiving Federal financial assistance under this Act.

(b) The Secretary may not approve an application under this section for assignment of a Corps member to a health manpower shortage area unless the Secretary has afforded—

(1) each health systems agency (designated under section 1515) for a health service area which includes all or part of the area in which the area, population group, medical facility, or other public facility so designated is located, or

(2) if there is a part of such area, population group, medical facility, or other public facility located within a health service area for which no health systems agency has been designated, the State health planning and development agency (designated under section 1521) of the State in which such part is located,

an opportunity to review the application and submit to the Secretary its comments respecting the need for, and proposed use of, the Corps member requested in the application. *Each health systems agency and State health planning and development agency shall in conducting its review under this subsection of an application consider comments submitted to the Secretary under subsection (c)(4) respecting such application.*

(c) In considering, and giving approval to, applications made under this section for the assignment of Corps members, the Secretary shall—

(1) give priority to an application which provides for the assignment of Corps members to an area, population group, medical facility, or other public facility with the greatest health manpower shortage, as determined under criteria established under section 332(b);

(2) give special consideration to an application which provides for the use of physician assistants, nurse practitioners, or expanded function dental auxiliaries;

(3) take into consideration the willingness of individuals in the area or population group, or at the medical facility or other public facility, and of the appropriate governmental agencies or health entities, to assist and cooperate with the Corps in providing effective health services; and

(4) take into consideration comments of medical, osteopathic, dental, or other health professional societies serving the area, population group, medical facility, or other public facility, or, if no such societies exist, comments of physicians, dentists, or other health professionals serving the area, population group, medical facility, or other public facility.

At least 90 days before approving such an application, the Secretary shall provide the appropriate health professions societies in the area to which an assignment would be made under the application the opportunity to submit comments on the assignment.

(d)(1) The Secretary may not approve an application for the assignment of a member of the Corps described in subparagraph (C) of section 331(a)(1)(C) to an entity unless the application of the entity contains assurances satisfactory to the Secretary that the entity (A) has sufficient financial resources to provide the member of the Corps with an income of not less than the income to which the member would be entitled if the member was a member described in subpara-

graph (B) of section 331(a)(1), or (B) would have such financial resources if a grant was made to the entity under paragraph (2).

(2)(A) If in approving an application of an entity for the assignment of a member of the Corps described in subparagraph (C) of section 331(a)(1) the Secretary determines that the entity does not have sufficient financial resources to provide the member of the Corps with an income of not less than the income to which the member would be entitled if the member was a member described in subparagraph (B) of section 331(a)(1), the Secretary may make a grant to the entity to assure that the member of the Corps assigned to it will receive during the period of assignment to the entity such an income.

(B) The amount of any grant under subparagraph (A) shall be determined by the Secretary. Payments under such a grant may be made in advance or by way of reimbursement, and at such intervals and on such conditions, as the Secretary finds necessary. No grant may be made unless an application therefor is submitted to and approved by the Secretary. Such an application shall be in such form, submitted in such manner, and contain such information, as the Secretary shall by regulation prescribe.

[(d)](e) The Secretary shall assign Corps members to entities in health manpower shortage areas without regard to the ability of the individuals in such areas, population groups, medical facilities, or other public facilities to pay for such services.

[(e)](f) In making the assignment of a Corps member to an entity in a health manpower shortage area which has had an application approved under this section, the Secretary shall seek to assign to an area a Corps member who has (and whose spouse, if any, has) those characteristics which are characteristics which increase the probability of the member's remaining to serve the area upon completion of his assignment period.

[(f)](g)(1) The Secretary shall provide technical assistance to a public or nonprofit private entity which is located or has a demonstrated interest in a health manpower shortage area and which desires to make an application under this section for assignment of a Corps member to such area. *Assistance provided under this paragraph shall include assistance to an entity in (A) analyzing the potential use of health professions personnel in defined health services delivery areas by the residents of such areas, (B) determining the need for such personnel in such areas, (C) determining the extent to which such areas will have a financial base to support the practice of such personnel and the extent to which additional financial resources are needed to adequately support the practice, and (D) determining the types of inpatient and other health services that should be provided by such personnel in such areas.*

(2) The Secretary shall provide, to public and nonprofit private entities which are located or have a demonstrated interest in a health manpower shortage area to which area a Corps member has been assigned, technical assistance to assist in the retention of such member in such area after the completion of such member's assignment to the area.

(3) The Secretary shall provide, to health manpower shortage areas to which no Corps member has been assigned, (A) technical assistance

to assist in the recruitment of health manpower for such areas, and (B) current information on public and private programs which provide assistance in the securing of health manpower.

(4) (A) The Secretary shall undertake to demonstrate the improvements that can be made in the assignment of members of the Corps to health manpower shortage areas and in the delivery of health care by Corps members in such areas through coordination with States, political subdivisions of States, agencies of States and political subdivisions, and other public and nonprofit private entities which have expertise in the planning, development, and operation of centers for the delivery of primary health care. In carrying out this subparagraph, the Secretary shall enter into agreements with qualified entities which provide that if—

(i) the entity places in effect a program for the planning, development, and operation of centers for the delivery of primary health care in health manpower shortage areas which reasonably addresses the need for such care in such areas, and

(ii) under the program the entity will perform the functions described in subparagraph (B),

the Secretary will assign under this section members of the Corps in accordance with the program.

(B) For purposes of subparagraph (A), the term "qualified entity" means a State, political subdivision of a State, an agency of a State or political subdivision, or other public or nonprofit private entity operating solely within one State, which the Secretary determines is able—

(i) to analyze the potential use of health professions personnel in defined health services delivery areas by the residents of such areas;

(ii) to determine the need for such personnel in such areas and to recruit, select, and retain health professions personnel (including members of the National Health Service Corps) to meet such need;

(iii) to determine the extent to which such areas will have a financial base to support the practice of such personnel and the extent to which additional financial resources are needed to adequately support the practice;

(iv) to determine the types of inpatient and other health services that should be provided by such personnel in such areas;

(v) to assist such personnel in the development of their clinical practice and fee schedules and in the management of their practice;

(vi) to assist in the planning and development of facilities for the delivery of primary health care; and

(vii) to assist in establishing the governing bodies of centers for the delivery of such care and to assist such bodies in defining and carrying out their responsibilities.

[(g)] *(h)* The Secretary shall conduct, or enter into contracts for the conduct of, studies of the methods of assignments of Corps members to health manpower shortage areas. Such studies shall include studies of—

(1) the characteristics of physicians, dentists, and other health professionals who are more likely to remain in practice in health manpower shortage areas;

(2) the characteristics, including utilization and reimbursement patterns, of areas which have been able to retain health manpower personnel; and

(3) the appropriate conditions for the assignment and use of nurse practitioners, physician assistants, and expanded function dental auxiliaries in health manpower shortage areas.

[(b)](*i*) Notwithstanding any other law, any member of the Corps licensed to practice medicine, osteopathy, or dentistry in any State shall, while serving in the Corps, be allowed to practice such profession in any State.

COST SHARING

SEC. 334. (a) The Secretary shall require, as a condition to the approval of an application under section 333 *for the assignment of a member of the Corps*, that the entity which submitted the application enter into an agreement for a specific assignment period (not to exceed 4 years) with the Secretary under which—

(1) the entity shall be responsible for charging, in accordance with subsection (d), for health services provided by Corps members assigned to the entity;

(2) the entity shall take such action as may be reasonable for the collection of payments for such health services, including, if a Federal agency, an agency of a State or local government, or other third party would be responsible for all or part of the cost of such health services if it had not been provided by Corps members under this subpart, the collection, on a fee-for-service or other basis, from such agency or third party, the portion of such cost for which it would be so responsible (and in determining the amount of such cost which such agency or third party would be responsible, the health services provided by Corps members shall be considered as being provided by private practitioners);

(3) the entity shall pay to the United States, as prescribed by the Secretary in each calendar quarter (or other period as may be specified in the agreement) during which any Corps member is assigned to such entity, the sum of—

(A) the portion of the salary (including amounts paid in accordance with section 331(d)) and allowances of any Corps member received by such member *from the United States* during such calendar quarter (or other period) while such member was assigned to such entity;

(B) for any Corps member assigned to such entity, an amount which bears the same ratio to the amount paid under the Scholarship Program to or on the behalf of such Corps member as the number of days of obligated service, provided by such member during such quarter (or other period) bears to the number of days in his period of obligated service under such Program; and

(C) if such entity received a loan *or grant* under section 335(c) *or a grant under section 333(d)(2)*, an amount which bears the same ratio to the amount of such loan *or grant* as the number of days in such quarter (or other period) during which any Corps members were assigned to the entity bears

to the number of days in the assignment period after such entity received such loan *or grant*; and

(4) the entity shall prepare and submit to the Secretary an annual report, in such form and manner, as the Secretary may require.

(b)(1) The Secretary may waive in whole or in part the application of the requirement of subsection (a)(3) for an entity if he determines that the entity is financially unable to meet such requirement or if he determines that compliance with such requirement would unreasonably limit the ability of the entity to provide for the adequate support of the provision of health services by Corps members.

(2) The Secretary may waive in whole or in part the application of the requirement of subsection (a)(3) for any entity which is located in a health manpower shortage area in which a significant percentage of the individuals are elderly, living in poverty, or have other characteristics which indicate an inability to repay, in whole or in part, the amounts required in subsection (a)(3).

(3) In the event that the Secretary grants a waiver under paragraph (1) or (2), the entity shall be required to use the total amount of funds collected by such entity in accordance with subsection (a)(2) for the improvement of the capability of such entity to deliver health services to the individuals in, or served by, the health manpower shortage area.

(4) In determining whether to grant a waiver under paragraph (1) or (2), the Secretary shall not discriminate against a public entity.

* * * * * * *

[(e) Funds received by the Secretary under an agreement entered into under this section shall be deposited in the Treasury as miscellaneous receipts and shall be disregarded in determining the amounts of appropriations to be requested and the amounts to be made available from appropriations made under section 338 to carry out this subpart.]

(e)(1) There is established in the Treasury of the United States a revolving fund to be called the National Health Service Corps Fund (hereinafter in this subsection referred to as the "Fund") which shall be available to the Secretary, without fiscal year limitation, to carry out this subpart.

(2) There shall be deposited in the Fund, subject to withdrawal by check by the Secretary—

(A) funds received by the Secretary after September 30, 1980, under an agreement entered into under subsection (a), and

(B) interest which may be earned on investments of the Fund.

(3) If the Secretary determines that the moneys of the Fund are in excess of current needs, the Secretary may request the investment of such amounts as the Secretary deems advisable by the Secretary of the Treasury in obligations of, or obligations guaranteed by, the Government of the United States, and, with the approval of the Secretary of the Treasury, in such other obligations or securities as it deems appropriate.

(4) With the approval of the Secretary of the Treasury, the Secretary of Health and Human Services may deposit moneys in the Fund

62-655 O - 80 - 10

in any Federal Reserve bank, any depository for public funds, or in such other places and in such manner as the Secretary of Health and Human Services and the Secretary of the Treasury may mutually agree.

(5) The Fund and the funds credited to it shall not be subject to apportionment under section 3679 of the Revised Statutes (31 U.S.C. 665).

* * * * * * *

SPECIAL GRANTS FOR FORMER CORPS MEMBERS TO ENTER PRIVATE PRACTICE

SEC. [755] *336.* (a) The Secretary may make one grant to an individual (other than an individual who has entered into an agreement under section 753)—

(1) who has completed *at least two years of* his period of obligated service in the Corps, and

(2) who has agreed in writing—

(A) to engage in the private full-time clinical practice of his profession in a health manpower shortage area (designated under section 332 and described in paragraphs (1) and (2) of section 753(a)) for a period (beginning not later than one year after the date he completed his period of obligated service in the Corps) of not less than one year;

(B) to conduct such practice in accordance with the provisions of section 753(b)(1); and

(C) to such additional conditions as the Secretary may require to carry out the purposes of this section;

to assist such individual in meeting the costs of beginning the practice of such individual's profession in accordance with such agreement, including the costs of acquiring equipment and renovating facilities for use in providing health services, and of hiring nurses and other personnel to assist in providing health services. Such grant may not be used for the purchase or construction of any building.

(b) The amount of the grant under subsection (a) to an individual shall be—

(1) $12,500, if the individual agrees to practice his profession in accordance with the agreement for a period of at least one year, but less than two years; or

(2) $25,000 if the individual agrees to practice his profession in accordance with the agreement for a period of at least two years.

(c) The Secretary may not make a grant under this section unless an application therefor has been submitted to, and approved by, the Secretary.

(d) If the Secretary determines that an individual has breached a written agreement entered into under subsection (a), he shall, as soon as practicable after making such determination notify the individual of such determination. If within 120 days after the date of giving such notice, such individual is not practicing his profession in accordance with the agreement under such subsection and has not provided assurances satisfactory to the Secretary that he will not knowingly violate such agreement again, the United States shall

be entitled to recover from such individual an amount determined under section 754(c), except that in applying the formula contained in such section "ø" shall be the sum of the amount of the grant made under subsection (a) to such individual and the interest on such amount which would be payable if at the time it was paid it was a loan bearing interest at the maximum legal prevailing rate, "t" shall be the number of months that such individual agreed to practice his profession under such agreement, and "s" shall be the number of months that such individual practices his profession in accordance with such agreement.

PREPARATION FOR PRACTICE

SEC. 337. (a) The Secretary may make grants to and enter into contracts with public and private nonprofit entities for the conduct of programs which are designed to prepare individuals subject to a service obligation under the National Health Service Corps Scholarship Program to effectively provide health services in the health manpower shortage area to which they are assigned.

(b) No grant may be made or contract entered into under subsection (a) unless an application therefor is submitted to and approved by the Secretary. Such an application shall be in such form, submitted in such manner, and contain such information, as the Secretary shall by regulation prescribe.

ANNUAL REPORTS

SEC. [336.] *338.* The Secretary shall submit an annual report to Congress on May 1 of each year, and shall include in such report with respect to the previous calendar year—

(1) the number, identity, and priority of all health manpower shortage areas designated in such year and the number of health manpower shortage areas which the Secretary estimates will be designated in the subsequent year;

(2) the number of applications filed under section 333 in such year for assignment of Corps members and the action taken on each such application;

(3) the number and types of Corps members assigned in such year to health manpower shortage areas, the number and types of additional Corps members which the Secretary estimates will be assigned to such areas in the subsequent year, and the need for additional members for the Corps;

(4) the recruitment efforts engaged in for the Corps in such year and the number of qualified individuals who applied for service in the Corps in such year;

(5) the number of patients seen and the number of patient visits recorded during such year with respect to each health manpower shortage area to which a Corps member was assigned during such year;

(6) the number of Corps members who elected, and the number of Corps members who did not elect, to continue to provide health services in health manpower shortage areas after termination of their service in the Corps and the reasons (as reported to the Sec-

retary) of members who did not elect for not making such election;

(7) the results of evaluations and determinations made under section 333(a)(1)(D) during such year; and

(8) the amount charged during such year for health services provided by Corps members, the amount which was collected in such year by entities in accordance with agreements under section 334, and the amount which was paid to the Secretary in such year under such agreements.

NATIONAL ADVISORY COUNCIL

SEC. [337.] *338A*. (a) There is established a council to be known as the National Advisory Council on the National Health Service Corps (hereinafter in this section referred to as the "Council"). The Council shall be composed of fifteen members appointed by the Secretary as follows:

(1) Four members shall be appointed from the general public to represent the consumers of health care, at least two of whom shall be individuals who are residents of, members of, or served by Corps members assigned to, a health manpower shortage area.

(2) Three members shall be appointed from medical, dental, and other health professions.

(3) One member shall be appointed from a State health planning and development agency (designated under section 1521), one member shall be appointed from a Statewide Health Coordinating Council (designated under section 1524), and one member shall be appointed from a health systems agency (designated under section 1515).

(4) Three members shall be appointed from the Service, at least two of whom shall be members of the Corps directly engaged in the provision of health services in a health manpower shortage area.

(5) Two members shall be appointed from the National Council on Health Planning and Development (established under section 1503.

No individual who is a provider of health care (as defined in section 1531(3)) may be appointed as a member of the Council under paragraph (1), (3), or (5). The Council shall consult with, advise, and make recommendations to, the Secretary with respect to his responsibilities in carrying out this subpart, and shall review and comment upon regulations promulgated by the Secretary under this subpart.

(b)(1) Members of the Council shall be appointed for a term of three years, except that any member appointed to fill a vacancy occurring prior to the expiration of the term for which the member's predecessor was appointed shall be appointed for the remainder of such term. No member shall be removed, except for cause. Members may be reappointed to the Council.

(2) Members of the Council (other than members who are officers or employees of the United States), while attending meetings or conferences thereof or otherwise serving on the business of the Council, shall be entitled to receive for each day (including travel-time) in

which they are so serving the daily equivalent of the annual rate of basic pay in effect for grade GS–18 of the General Schedule; and while so serving away from their homes or regular places of business all members may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5 of the United States Code for persons in the Government service employed intermittently.

(c) Section 14 of the Federal Advisory Committee Act shall not apply with respect to the Council.

AUTHORIZATION OF APPROPRIATION

SEC. [338.] *338B.* (a) To carry out the purposes of this subpart, there are authorized to be appropriated $47,000,000 for the fiscal year ending September 30, 1978; $64,000,000 for the fiscal year ending September 30, 1979; [and] $82,000,000 for the fiscal year ending September 30, 1980*; $94,000,000 for the fiscal year ending September 30, 1981; $145,000,000 for the fiscal year ending September 30, 1982; and $205,000,000 for the fiscal year ending September 30, 1983.*

* * * * * * *

TITLE VII—HEALTH RESEARCH AND TEACHING FACILITIES AND TRAINING OF PROFESSIONAL HEALTH PERSONNEL

PART A—GENERAL PROVISIONS

GRADUATE MEDICAL EDUCATION NATIONAL ADVISORY COMMITTEE

SEC. 712. (a)(1) There is established the Graduate Medical Education National Advisory Committee (hereinafter in this section referred to as the "Advisory Committee"). The Advisory Committee shall consist of 23 members as follows:

(A) A representative of the Public Health Service and a representative of the Health Care Financing Administration each designated by the Secretary, a representative of the Department of Defense designated by the Secretary of Defense, a representative of the Veterans' Administration designated by the Administrator of Veterans' Affairs, and the Chairman of the Coordinating Council on Medical Education shall each be ex officio members of the Advisory Committee.

(B) The Secretary shall appoint 18 members from individuals who are representative of providers of health care, insurers and other payers of health care, and interested national and local organizations.

(2)(A) Except as provided in subparagraph (B), the term of office of a member of the Advisory Committee shall be three years.

(B) Of the members first appointed to the Advisory Committee after the date of the enactment of this section—

(i) six members shall be appointed to serve for terms of one year, and

(ii) six members shall be appointed to serve for terms of two years,

as designated by the Secretary at the time of appointment. Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of such term. A member may serve after the expiration of the member's term until a successor has taken office.

(3) Members of the Advisory Committee who are officers or employees of the United States shall serve without pay. The other members of the Advisory Committee shall be entitled to receive the daily equivalent of the annual rate of basic pay in effect for grade GS–18 of the General Schedule for each day (including traveltime) during which they are engaged in the actual performance of the duties vested in the Committee.

(4) The chairman of the Advisory Committee shall be designated by the Secretary from the appointed members of the Advisory Committee.

(5) The Advisory Committee shall meet at the call of the chairman, except that the Advisory Committee shall meet at least once every calendar quarter. Notice of meetings of the Advisory Committee shall be made available to the public and such meetings shall be open to the public.

(6) The Secretary shall provide the Advisory Committee such support staff and administrative services as may be necessary for the Advisory Committee to carry out its functions under subsection (b).

(b) The Advisory Committee shall—

(1) advise, consult with, and make recommendations to, the Secretary with respect to—

(A) the need for and supply of physicians in the various medical specialties (including subspecialties) and with respect to the geographic distribution of physicians;

(B) the factors which affect a physician's choice of graduate medical training and the location of the physician's practice;

(C) the effect that—

(i) the rate of reimbursement for health care services provided by physicians in the different medical specialties, and

(ii) the availability of financial support for persons undergoing graduate medical education,

has on the selection of a medical specialty or subspecialty;

(D) the proportion of health services provided by persons undergoing graduate medical education; and

(E) such other matters relating to graduate medical education as the Secretary may specify.

(2) recommend to the Secretary goals for (A) the distribution of physicians by medical specialties and subspecialties, and (B) the number of graduate medical education positions that should be available in each of the medical specialties and subspecialties; and

(3) recommend to the Secretary policies and procedures to achieve such goals.

The Advisory Committee shall inform the Secretary of the data it will need to carry out its functions under this subsection.

(c)(1) The Advisory Committee shall consult with appropriate entities, including the Coordinating Council on Medical Education and its constituent members, concerning appropriate actions to attain the goals recommended under subsection (b)(2).

(2) The Secretary may enter into contracts with public and other nonprofit entities, including the Coordinating Council on Medical Education and its constituent members, to provide assistance to the Advisory Committee in carrying out its functions under subsection (b).

(d) The Advisory Committee shall consult with the Health Care Financing Administration and private health insurance carriers concerning any changes in the rates of reimbursements for health services provided by physicians in graduate medical education training programs and other practicing physicians necessary to provide incentives to achieve the goals recommended by the Advisory Committee for the distribution of physicians by medical specialties.

(e) The Advisory Committee shall submit to the Secretary an annual report respecting the activities of the Advisory Committee. The Advisory Committee shall include in such report a description of the consultations undertaken under subsections (c) and (d).

Part B—Grants and Loan Guarantees and Interest Subsidies for Construction of Teaching Facilities for Medical, Dental, and Other Health Personnel

grant authority; authorization of appropriations

Sec. 720. (a)(1) The Secretary may make grants to assist in the construction of teaching facilities for the training of physicians, dentists, pharmacists, optometrists, podiatrists, veterinarians, and professional public health personnel.

(2)(A) The Secretary may make grants to public and nonprofit private entities to assist in the construction of ambulatory, primary care teaching facilities for the training of physicians and dentists.

(B) For purposes of this section, the term "ambulatory, primary care teaching facilities" means areas dedicated for the training of students in the diagnosis and treatment of ambulatory patients and primarily in the specialties of family practice, general pediatrics, general internal medicine, general dentistry, and pedodontics. Such areas may include examination rooms, clinical laboratories, libraries, classrooms, offices, and other areas for clinical or research purposes necessary for, and appropriate to, the conduct of comprehensive ambulatory, primary care training of physicians and dentists in such specialties.

(3) The Secretary may make grants to schools providing the first two years of education leading to the degree of doctor of medicine to assist in the construction of the teaching facilities which the schools require to become schools of medicine.

[(b) For payments under grants under this part there is authorized to be appropriated $40,000,000 for the fiscal year ending September 30, 1978, $40,000,000 for the fiscal year ending September 30, 1979, and $40,000,000 for the fiscal year ending September 30,

1980. Of the sums appropriated under this subsection for any fiscal year 50 percent of such sums shall be obligated for grants under subsection (a)(1) and 50 percent of such sums shall be obligated for grants under subsection (a)(2).]

(b) For the purpose of grants under subsection (a)(3), there are authorized to be appropriated $15,000,000 for the fiscal year ending September 30, 1981, to remain available until expended.

APPROVAL OF APPLICATIONS

SEC. 721. (a) The Secretary may from time to time set dates (not earlier than in the fiscal year preceding the year for which a grant is sought) by which applications for grants under this part for any fiscal year must be filed.

(b)(1) *To be eligible to apply for a grant under section 720(a)(3) the applicant must be a public or nonprofit school providing the first two years of education leading to the degree of doctor of medicine and be accredited by a recognized body or bodies approved for such purpose by the Secretary of Education.* To be eligible to apply for a grant to assist in the construction of any facility under [this part] *paragraph (1) or (2) of section 720(a);* the applicant must be (A) a public or other nonprofit school of medicine, dentistry, osteopathy, pharmacy, optometry, podiatry, veterinary medicine, or public health, and (B) accredited by a recognized body or bodies approved for such purpose by the Commissioner of Education, except that a new school which (by reason of no, or an insufficient, period of operation) is not, at the time of application for a grant under section 720(a)(1) to construct a facility under this part, eligible for accreditation by such a recognized body or bodies, shall be deemed accredited for purposes of this part if the Commissioner of Education finds, after consultation with the appropriate accreditation body or bodies, that there is reasonable assurance that the school will meet the accreditation standards of such body or bodies; (i) prior to the beginning of the academic year following the normal graduation date of the first entering class in such school or (ii) if later, upon completion of the project for which assistance is requested and other projects (if any) under construction or planned and to be commenced within a reasonable time, or (C) any combination of schools which are described in clause (A) and which meet the requirements of clause (B).

* * * * * * *

(c) A grant under section 720(a)(1) may be made only if the application therefor is approved by the Secretary upon his determination that—

(1) the applicant meets the eligibility conditions set forth in subsection (b);

(2) the application contains or is supported by reasonable assurances that (A) the facility is intended to be used for the purposes for which the application has been made, (B) sufficient funds will be available to meet the non-Federal share of the cost of constructing the facility, *and* (C) sufficient funds will be available, when construction is completed, for effective use of

the facility for the training for which it is being constructed [, and (D) in the case of an application for construction to expand the training capacity of an existing school of medicine, dentistry, osteopathy, pharmacy, optometry, podiatry, veterinary medicine, or public health, the first-year enrollment at such school during the first full school year after the completion of the construction and for each of the next nine school years thereafter will exceed the highest first-year enrollment at such school for any of the five full school years preceding the year in which the application is made by at least 5 per centum of such highest first-year enrollment, or by five students, whichever is greater, and the requirements of this clause (D) shall be in addition to the requirements of section 771 of this Act, where applicable;];

* * * * * * *

(g)(1) A grant under [section 720(a)(2)] *paragraph (2) or (3) of section 720(a)* may be made only if the application therefor is approved by the Secretary upon his determination that—

(A) the application contains or is supported by reasonable assurances that (i) the facility is intended to be used for purposes for which the application has been made, (ii) sufficient funds will be available to meet the non-Federal share of the cost of constructing the facility, and (iii) sufficient funds will be available, when construction is completed, for effective use of the facility for the training for which it is being constructed;

(B) the plans and specifications are in accordance with regulations relating to minimum standards of construction and equipment; and

(C) the application contains or is supported by adequate assurance that any laborer or mechanic employed by a contractor or subcontractors in the performance of work on the construction of the facility will be paid wages at rates not less than those prevailing on similar construction in the locality as determined by the Secretary of Labor in accordance with the Act of March 3, 1931 (40 U.S.C. 276a—267a–5, known as the Davis-Bacon Act.)

The Secretary of Labor shall have with respect to the labor standards specified in subparagraph (C) the authority and functions set forth in Reorganization Plan Numbered 14 of 1950 (15 F.R. 3176; 5 U.S.C. Appendix) and section 2 of the Act of June 13, 1934 (40 U.S.C. 276c).

AMOUNT OF GRANT; PAYMENTS

SEC. 722. (a)(1) The amount of any grant under section 720(a)(1) for construction of a project shall be such amount as the Secretary determines to be appropriate after obtaining advise from the Council, except that no grant for any project may exceed 80 percent of the necessary costs of construction, as determined by the Secretary, of such project.

(2) The amount of any grant under section 720(a)(2) for construction of a facility shall be such amount as the Secretary determines

to be appropriate, except that no grant for any facility may exceed the lesser of—

(A) 50 percent of the total of such facility, or

(B) $1,000,000.

(3) The amount of any grant under section 720(a)(3) shall be such amount as the Secreatry determines to be appropriate after obtaining advice from the Council, except that no grant for any project may exceed 80 percent of the necessary costs of construction. as determined by the Secretary.

* * * * * * *

RECAPTURE OF PAYMENTS

SEC. 723. (a) If, within twenty years (or in the case of interim facilities, within such shorter period as the Secretary shall by regulation prescribe) after completion of any construction for which funds have been under a grant under *section 720(a)(1) paragraph (1) or (3) of section 720(a)*—

(1) the applicant or other owner of the facility shall cease to be a public or nonprofit school or, in case the facility was an affiliated hospital or outpatient facility, the applicant or other owner of the facility ceases to be a public or other nonprofit agency qualified to file an application under section 605, or

(2) the facility shall cease to be used for the teaching purposes (and the other purposes permited under section 722) for which it was constructed, unless the Secretary determines, in accordance with regulations, that there is good cause for releasing the applicant or other owner from the obligation to do so, or

(3) the facility is used for sectarian instruction or as a place for religious worship,

the United States shall be entitled to recover from the applicant or other owner of the facility the amount bearing the same ratio to the then value (as determined by agreement of the parties or by action brought in the United States district court for the district in which such facility is situated) of the facility, as the amount of the Federal participation bore to the cost of construction of such facility.

* * * * * * *

LOAN GUARANTEES AND INTEREST SUBSIDIES

SEC. 726. (a) To assist nonprofit private entities to carry out approved [construction projects for] *projects for the remodeling, renovation, or alteration of* teaching facilities, the Secretary may, during the period beginning July 1, 1971, and ending with the close of September 30, [1980,] *1983*, guarantee (in accordance with this section and subject to subsection (f)) to any non-Federal lender or the Federal Financing Bank which makes a loan to such an entity for such a project payment when due of the principal of and interest on such loan if such entity is elgibile (as determined under regulations of the Secretary) for a grant under this part for such project. The Secretary may make commitments, on behalf of the United States, to make such loan guarantees prior to the making of such loans. No such loan guar-

antee may, except under special circumstances and under such conditions as are prescribed by regulations, apply to any amount which, when added to any grant under this part or any other law of the United States, exceeds 90 percent of the *cost of the construction project, cost of the project, including architect fees and the initial equipment of the remodeled, renovated, or alterated teaching facilities.*

(b) In the case of any nonprofit private entity which is eligible (as determined under regulations of the Secretary) for a grant under this part to assist it in carrying out an approved construction project for teaching facilities after June 30, 1971, and to whom a loan has been made *before October 1, 1980*, by a non-Federal lender or the Federal Financing Bank to assist is in carrying out such project, the Secretary[, during the period beginning July 1, 1971, and ending with the close of September 30, 1980,] may, subject to subsection (f), pay to the holder of such loan (and for and on behalf of the entity which received such loan) amounts sufficient to reduce by not to exceed 3 per centum per annum the net effective interest rate otherwise payable on such loan.

* * * * * * *

Part C—Student Assistance

* * * * * * *

scope and duration of federal loan insurance program

Sec. 728. (a) The total principal amount of new loans made and installments paid pursuant to lines of credit (as defined in section 737) to borrowers covered by Federal loan insurance under this subpart shall not exceed $500,000,000 for the fiscal year ending September 30, 1978; $510,000,000 for the fiscal year ending September 30, 1979; and $520,000,000 for the fiscal year ending September 30, 1980, *and for each of the next three fiscal years.* Thereafter, Federal loan insurance pursuant to this subpart may be granted only for loans made (or for loan installments paid pursuant to lines of credit) to enable students, who have obtained prior loans insured under this subpart, to continue or complete their educational program or to obtain a loan under section 731(a)(1)(B) to pay interest on such prior loans; but no insurance may be granted for any loan made or installment paid after September 30, [1982] *1985.*

* * * * * * *

limitations on individual federally insured loans and on federal loan insurance

Sec. 729. (a) The total of the loans made to a student in any academic year or its equivalent (as determined by the Secretary) which may be covered by Federal loan insurance under this subpart may not exceed $10,000 in the case of a student enrolled in a school of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, or public health, and $7,500 in the case of a student enrolled in a school of pharmacy, except that in the case of loans to students in schools of medicine, osteopathy, and dentistry, the Secretary may increase the total of such loans which may be covered by Federal loan insurance to [$15,000] *$20,000* if he determines that the costs of educa-

tion at such schools requires such increase. The aggregate insured unpaid principal amount for all such insured loans made to any borrower shall not any time exceed $50,000 in the case of a borrower who is or was a student enrolled in a school of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, or public health, and $37,500 in the case of a borrower who is or was a student enrolled in a school of pharmacy, except that the Secretary may increase such amount for borrowers who are or were students in schools of medicine, osteopathy, and dentistry to [$60,000] *$80,000* if he determines that the costs of education at such schools requires such increase. The annual insurable limit per student shall not be exceeded by a line of credit under which actual payments by the lender to the borrower will not be made in any year in excess of the annual limit.

* * * * * * *

ELIGIBILITY OF STUDENT BORROWERS AND TERMS OF FEDERALLY INSURED LOANS

SEC. 731. (a) A loan by an eligible lender shall be insurable by the Secretary under the provisions of this subpart only if—

(1) made to—

(A) student who—

(i) (I) has been accepted for enrollment at an eligible institution, or (II) in the case of a student attending an eligible institution, is in good standing at that institution, as determined by the institution;

(ii) is or will be a full-time student (as defined in section 770(c)(2)) at the eligible institution;

(iii) in the case of a student in a school of medicine, osteopathy, or dentistry, has been authorized by the institution in accordance with section 739(b)(2) to recieve a loan under this subpart;

(iv) has agreed that all funds received under such loan shall be used solely for tuition and other reasonable educational expenses, including fees, books, and laboratory expenses, incurred by such students; *and*

[(v) for the school year for which such loan is made, receives no funds from a loan insured under a Federal, State, or non-profit program provided or assisted under part B of title IV of the Higher Education Act of 1965; and]

[(vi)] (*v*) in the case of a pharmacy student, has satisfactorily completed three years of training; or

* * * * * * *

(2) evidenced by a note or other written agreement which—

(A) is made without security and without endorsement, except that if the borrower is a minor and such note or other written agreement executed by him would not, under the applicable law, create a binding obligation, an endorsement may be required;

(B) provides for repayment of the principal amount of the loan in installments over a period of not less than 10

years (unless sooner repaid) nor more than 15 years beginning not earlier than 9 months nor later than 12 months after the date on which the borrower ceases to be a participant in an accredited internship or residency program or (if he was not a participant in such a program) ceases to carry, at an eligible institution, the normal full-time academic workload as determined by the institution, except (i) as provided in clause (C) below, (ii) that the period of the loan may not exceed 23 years from the date of execution of the note or written agreement evidencing it, and (iii) that the note or other written instrument may contain such provisions relating to repayment in the event of default in the payment of interest or in the payment of the costs of insurance premiums, or other default by the borrower, as may be authorized by regulations of the Secretary in effect at the time the loan is made;

(C) provides that periodic installments of principal *and interest* need not be paid, but interest shall accrue [and be paid,] during any period (i) during which the borrower is pursuing a full-time course of study at an eligible institution (or at an institution defined by section 435(b) of the Higher Education Act of 1965), (ii) not in excess of [three] *four* years during which the borrower is a participant in an accredited internship or residency program, (iii) not in excess of three years, during which the borrower is a member of the Armed Forces of the United States, (iv) not in excess of three years during which the borrower is in service as a volunteer under the Peace Corps Act, (v) not in excess of three years during which the borrower is a member of the National Health Service Corps, or (vi) not in excess of three years during which the borrower is in service as a full-time volunteer under title I of the Domestic Volunteer Service Act of 1973, and any such period shall not be included in determining the 15-year period or the 23-year period provided in clause (B) above;

(D) provides for interest on the unpaid principal balance of the loan at a yearly rate, not exceeding the applicable maximum rate prescribed and defined by the Secretary (within the limits set forth in subsection (b)) on a national, regional, or other appropriate basis, which interest shall be compounded semiannually and payable in installments over the period of the loan, *except as provided in paragraph (C)*, except that the note or other written agreement may provide that payment of any interest [otherwise payable (i) before the beginning of the repayment period, (ii) during any period described in subparagraph (C), or (iii) during any other period of forebearance of payment of principal,] may be deferred until not later than the date upon which repayment of the first installment of principal falls due or the date repayment of principal is required to resume (whichever is applicable) and may further provide that, on such date, the amount of the interest which has so accrued may be added to the principal;

(E) offers, in accordance with criteria prescribed by regulation by the Secretary, a schedule for repayment of principal and interest under which payment of a portion of the principal and interest otherwise payable at the beginning of the repayment period (as defined in such regulations) is deferred until a later time in the period;

[(E)] *(F)* entitles the borrower to accelerate without penalty repayment of the whole or any part of the loan; and

[(F)] *(G)* contains such other terms and conditions consistent with the provisions of this subpart and with the regulations issued by the Secretary pursuant to this subpart, as may be agreed upon by the parties to such loan, including, if agreed upon, a provision requiring the borrower to pay to the lender, in addition to principal and interest, amounts equal to the insurance premiums payable by the lender to the Secretary with respect to such loan.

(b) No maximum rate of interest prescribed and defined by the Secretary for the purpose of paragraph (2)(D) of subsection (a) may exceed [12 percent per anum on the unpaid principal balance of the loan] *the average of the bond equivalent rates of the 91-day Treasury bills auctioned for the previous quarter plus 2 percent.*

(c) [The] *Except as provided in subsection (a)(2)(C), the* total of the payments by a borrower during any year or any repayment period with respect to the aggregate amount of all loans to that borrower which are insured under this subpart shall not be less than the annual interest on the outstanding principal.

(d) No provision of any law of the United States (other than subsections (a)(2)(D) and (b) of this section) or of any State that limits the rate or amount of interest payable on loans shall apply to a loan insured under this subpart.

POWERS AND RESPONSIBILITIES

SEC. 735. (a) * * *

* * * * * * *

(c)(1) The Secretary may enter into a written contract with a borrower under which the Secretary agrees to assume the obligations of paying an amount, not to exceed $10,000 in any 12-month period, toward the principal and interest due on any loan made to the borrower and insured under this subpart and the borrower agrees to serve, either as a member of the National Health Service Corps or in private practice pursuant to section 753 (as determined by the Secretary), in a health manpower shortage area (designated under section 332) which is described in [clauses (A) and (B) of] section 753(a)(2) for a continuous period of (A) not less than 12 months for each 12-month period the Secretary assumes such obligation under the agreement, or (B) 24 months, whichever is greater.

* * * * * * *

DEFINITIONS

SEC. 737. As used in this subpart:

[(1) The term "eligible institution" means, with respect to a fiscal year, a school of medicine, osteopathy, dentistry, optometry, pharmacy,

podiatry, veterinary medicine, or public health within the United States that (A) received a grant, or the Secretary determines met the requirements for receipt of a grant, under section 770 for the preceding fiscal year, or (B) was not eligible to receive such a grant for such fiscal year solely because it did not meet the applicable requirements of section 771(b)(3).]

(1) The term "eligible institution" means a school of medicine, osteopathy, dentistry, veterinary medicine, optometry, pharmacy, podiatry, or public health within the United States which is accredited by a recognized body or bodies approved for such purpose by the Secretary of Education.

* * * * * * *

Subpart II—Students Loans

* * * * * * *

ELIGIBILITY OF INSTITUTIONS

SEC. 739. (a) * * *

[(b) The Secretary shall by regulation—

[(1) require an eligible institution to record, and make available to a lender and to the Secretary upon request, the name, address, postgraduate destination, and other reasonable identifying information for each student of such institution who has a loan insured under this subpart; and

[(2) in the case of an eligible institution which is a school of medicine, osteopathy, or dentistry, require such institution to establish procedures to insure that no more than 50 percent of the students in each class in the institution are authorized to have loans insured under this subpart.]

(b) The Secretary shall require an eligible institution to record, and to make available to the lender and to the Secretary upon request, the name, address, postgraduate destination, and other reasonable identifying information for each student of such institution who has a loan insured under this subpart.

* * * * * * *

AUTHORIZATION OF APPROPRIATIONS

SEC. 742. (a) For the purpose of making Federal capital contributions into the student loan funds of schools which have established such funds under section 740, there are authorized to be appropriated $26,000,000 for the fiscal year ending September 30, 1978, $27,000,000 for the fiscal year ending September 30, 1979, [and] $28,000,000 for the fiscal year ending September 30, 1980, *$20,000,000 for the fiscal year ending September 30, 1981, $22,500,000 for the fiscal year ending September 30, 1982, and $25,000,000 for the fiscal year ending September 30, 1983.* For the fiscal year ending September 30, [1981,] *1984*, and each of the two succeeding fiscal years, there are authorized to be appropriated to the Secretary such sums as may be necessary to enable students who have received a loan under this part for any academic year ending before October 1, [1980,] *1983*, to continue or complete their education.

* * * * * * *

DISTRIBUTION OF ASSETS FROM LOAN FUNDS

SEC. 743. (a) After September 30, [1983,] *1986*, and not later than December 31, 1983, there shall be a capital distribution of the balance of the loan fund established under an agreement pursuant to section 740(b) by each school as follows:

(1) The Secretary shall first be paid an amount which bears the same ratio to such balance in such fund at the close of September 30, [1983,] *1986*, as the total amount of the Federal capital contributions to such fund by the Secretary pursuant to section 740(b)(2)(A) bears to the total amount in such fund derived from such Federal capital contributions and from funds deposited therein pursuant to section 740(b)(*2*)(B).

(2) The remainder of such balance shall be paid to the school.

(b) After December 31, [1983,] *1986*, each school with which the Secretary has made an agreement under this subpart shall pay to the Secretary, not less often then quarterly, the same proportionate share of amounts received by the school after September 30, [1983,] *1986*, in payment of principal or interest on loans made from the loan fund established pursuant to such agreement as was determined for the Secretary under subsection (a).

* * * * * * *

Subpart IV—National Health Service Corps Scholarships

NATIONAL HEALTH SERVICE CORPS SCHOLARSHIP PROGRAM

SEC. 751. (a) The Secretary shall establish the National Health Service Corps Scholarship Program (hereinafter in this subpart referred to as the "Scholarship Program") to assure an adequate supply of trained physicians, dentists, and nurses for the National Health Service Corps (hereinafter in this subpart referred to as the "Corps") and, if needed by the Corps, podiatrists, optometrists, pharmacists, *clinical psychologists*, graduates of schools of veterinary medicine, graduates of schools of public health, graduates of programs in health administration, graduates of programs for the training of physicians assistants, expanded function dental auxiliaries, and nurse practitioners (as defined in section 822), and other health professionals.

* * * * * * *

(c) In disseminating application forms and contract forms to individuals desiring to participate in the Scholarship Program, the Secretary shall include with such forms—

(1) a fair summary of the rights and liabilities of an individual whose application is approved (and whose contract is accepted) by the Secretary, including in the summary a clear explanation of the damages to which the United States is entitled under section 754 in the case of the individual's breach of the contract; and

(2) *information respecting meeting a service obligation through private practice under an agreement under section 753 and* such other information as may be necessary for the individual to understand the individual's prospective participation in the Scholarship Program and service in the Corps.

The application form, contract form, and all other information furnished by the Secretary under this subpart shall be written in a manner calculated to be understood by the average individual applying to participate in the Scholarship Program. The Secretary shall make such application forms, contract forms, and other information available to individuals desiring to participate in the Scholarship Program on a date sufficiently early to insure that such individuals have adequate time to carefully review and evaluate such forms and information.

(d) In determining which applications under the Scholarship Program to approve (and which contracts to accept), the Secretary shall give priority—

(1) first, to applications made (and contracts submitted) by individuals who have previously received scholarships under the Scholarship Program or under section 758; and

(2) second, to applications made (and contracts submitted)—

(A) for the school year beginning in calendar year 1978, by individuals who are entering their first, second, or third year of study in a course of study or program described in subsection (b) (1) (B) in such school year.

(B) for the school year beginning in calendar year 1979, by individuals who are entering their first or second year of study in a course of study or program described in subsection (b) (1) (B) in such school year; and

(C) for each school year thereafter, by individuals who are entering their first year of study in a course of study or program described in subsection (b) (1) (B) in such school year.

In considering applications and contracts for which a priority is required under paragraph (2), the Secretary shall give special consideration to the applications and contracts of individuals who intend to be primary care physicians in health manpower shortage areas (as defined in section 332), who have resided or been employed in such areas, or who meet such other qualifications as the Secretary may prescribe to assist in determining if an individual will become a primary care physician in such an area.

* * * * * * *

OBLIGATED SERVICE

SEC. 752. (a) Except as provided in section 753, each individual who has entered into a written contract with the Secretary under section 751 shall provide service in the full-time clinical practice of such individual's profession as a member of the Corps for the period of obligated service provided in such contract.

[(b) (1) The Secretary shall notify each individual required to provide service under the Scholarship Program, not later than 60 days before the date described in paragraph (5), of the opportunity of such individual to serve in the full-time clinical practice of his profession either as a commissioned officer in the Regular or Reserve Corps of the Service or as a civilian member of the Corps. The Secretary shall include in such notice sufficient information regarding the advantages and disadvantages to each alternative to enable an individual to make a decision on an informed basis.

62-655 O - 80 - 11

[(2) To be eligible to provide obligated service as a commissioned officer in the Service, an individual shall notify the Secretary, not later than 30 days before the date described in paragraph (5), of the individual's desire to provide such service as such an officer.

[(3) If an individual who has notified the Secretary under paragraph (2) qualifies for an appointment as such an officer, the Secretary shall, as soon as possible after the date described in paragraph (5), appoint the individual as a commissioned officer of the Regular or Reserve Corps and of the Service and shall designate the individual as a member of the Corps. If an individual who has notified the Secretary under paragraph (2) does not so qualify, the Secretary shall, as soon as possible after the date described in paragraph (5), appoint such individual in accordance with paragraph (4).

[(4) Except as provided in paragraph (3) and in section 753, the Secretary shall appoint each individual, as soon as possible after the date described in paragraph (5), to serve in the full-time clinical practice of his profession as a civilian member of the Corps.]

(b)(1) If an individual is required under subsection (a) to provide service as specified in section 751(f)(1)(B)(iv) (hereinafter in this subsection referred to as "obligated service"), the Secretary shall, not later than 90 days before the date described in paragraph (5), determine if the individual shall provide such service—

(A) as a member of the Corps who is a commissioned officer in the Regular or Reserve Corps of the Service or who is a civilian employee of the United States, or

(B) as a member of the Corps who is not such an officer or employee,

and shall notify such individual of such determination.

(2) If the Secretary determines that an individual shall provide obligated service as a member of the Corps who is a commissioned officer in the Service or a civilian employee of the United States, the Secretary shall, not later than 60 days before the date described in paragraph (5), provide such individual with sufficient information regarding the advantages and disadvantages of service as such a commissioned officer or civilian employee to enable the individual to make a decision on an informed basis. To be eligible to provide obligated service as a commissioned officer in the Service, an individual shall notify the Secretary, not later than 30 days before the date described in paragraph (5), of the individual's desire to provide such service as such an officer. If an individual qualifies for an appointment as such an officer, the Secretary shall, as soon as possible after the date described in paragraph (5), appoint the individual as a commissioned officer of the Regular or Reserve Corps of the Service and shall designate the individual as a member of the Corps.

(3) If an individual provided notice by the Secretary under paragraph (2) does not qualify for appointment as a commissioned officer in the Service, the Secretary shall appoint such individual as a civilian employee of the United States and designate the individual as a member of the Corps.

(4) If the Secretary determines that an individual shall provide obligated service as a member of the Corps who is not an employee of the United States, the Secretary shall as soon as possible after the date

described in paragraph (5), designate such individual as a member of the Corps to provide such service.

(5)(A) With respect to an individual receiving a degree from a school of medicine, osteopathy, or dentistry, the date referred to in paragraphs (1) through (4) shall be the date upon which the individual completes the training required for such degree, except that the Secretary shall, at the request of such individual, defer such date until the end of the period of time (not to exceed three years or such greater period as the Secretary, consistent with the needs of the Corps, may authorize) required for the individual to complete an internship, residency, or other advanced clinical training. With respect to an individual receiving a degree from a school of veterinary medicine, optometry, podiatry, or pharmacy, the date referred to in paragraphs (1) through (4) shall be the date upon which the individual completes the training required for such degree, except that the Secretary shall, at the request of such individual, defer such date until the end of the period of time (not to exceed one year or such greater period as the Secretary, consistent with the needs of the Corps, may authorize) required for the individual to complete an internship, residency, or other advanced clinical training. No period of internship, residency, or other advanced clinical training shall be counted toward satisfying a period of obligated service under this subpart.

(B) With respect to an individual receiving a degree from an institution other than a school referred to in subparagraph (A); the date referred to in paragraphs (1) through (4) shall be the date upon which the individual completes his academic training leading to such degree.

(c) An individual shall be considered to have begun serving a period of obligated service—

(1) on the date such individual is appointed as an officer in a Regular or Reserve Corps of the Service [or as a member of the Corps] *or as a civilan employee of the United States or is designated as a member of the Corps under subsection (b)(4)*, or

(2) in the case of an individual who has entered into an agreement with the Secretary under section 753, on the date specified in such agreement,

whichever is earlier.

(d) The Secretary shall assign individuals performing obligated service in accordance with a written contract under the Scholarship Program to health manpower shortage areas in accordance with subpart II of part D of title III. If the Secretary determines that there is no need in a health manpower shortage area (designated under section 332) for a member of the profession in which an individual is obligated to provide service under a written contract *and if such individual is an officer in the Service or a civilian employee of the United States*, the Secretary may detail such individual to serve his period of obligated service as a full-time member of such profession in such unit of the Department as the Secretary may determine.

[(e) Notwithstanding any other provision of this title, if the Secretary determines that an individual who is or has been a participant in the Scholarship Program demonstrates exceptional promise for medical research, the Secretary may permit such individual to perform

his service obligation under the National Research Service Award program established under section 472.]

(e) Notwithstanding any other provision of this title, service of an individual under a National Research Service Award awarded under subparagraph (A) or (B) of section 472(a)(1) shall be counted against the obligated service which the individual is required to perform under the Scholarship Program.

PRIVATE PRACTICE

SEC. 753. (a) The Secretary shall release an individual from all or part of his service obligation under section 752(a) *or under section 225 (as in effect on September 30, 1977)* if the individual applies for such a release under this section and enters into a written agreement with the Secretary under which the individual agrees to engage for a period equal to the remaining period of his service obligation in the full-time private clinical practice (including service as a salaried employee in an entity directly providing health services) of his health profession—

(1) in the case of an individual who is performing obligated service as a member of the Corps in a health manpower shortage area on the date of his application for such a release, in the health manpower shortage area in which such individual is serving on such date; or

(2) in the case of any other individual, in a health manpower shorage area (designated under section 332) [which (A) has a priority for the assignment of Corps members under section 33(c), and (B) has a sufficient financial base to sustain such private practice and to provide the individual with income of not less than the income of members of the Corps.

In the case of an individual described in paragraph (1), the Secretary shall release the individual from his service obligation under this subsection only if the Secretary determines that the area in which the individual is serving meets the requirements of clase (B) of paragraph (2).].

(b) The written agreement described in subsection (a) shall—

(1) provide that during the period of private practice by an individual pursuant to the agreement—

(A) any person who receives health services provided by the individual in connection with such practice will be charged for such services at the usual and customary rate prevailing in the area in which such services are provided, except that if such person is unable to pay such charge, such person shall be charged at reduced rate or not charged any fee; and

(B) the individual in providing health services in connection with such practice (*i*) shall not discriminate against any person on the basis of such person's ability to pay for such services or because payment for the health services provided to such person will be made under the insurance program established under part A or B of title XVIII of the Social Security Act or under a State plan for medical

assistance approved under title XIX of such Act, *and (ii) shall agree to accept an assignment under section 1842(b)(3)(B)(ii) of such Act for all services for which payment may be made under part B of title XVIII and enter into an appropriate agreement with the State agency which administers the State plan for medical assistance under title XIX of such Act to provide services to individuals entitled to medical assistance under the plan;* and

* * * * * *

(c) If an individual breaches the contract entered into under section 751 by failing (for any reason) to bring his service obligation in accordance with an agreement entered into under subsection (a) or to complete such service obligation, the Secretary may permit such individual to perform such service obligation as a member of the Corps.

(d) The Secretary shall, upon request, provided technical assistance to individuals who are considering entering into an agreement under subsection (a) or have entered into such an agreement to assist them in the establishment of their clinical practice under the agreement.

BREACH OF SCHOLARSHIP CONTRACT

SEC. 754. (a) * * *

* * * * * * *

[(c) If] *(c)(1) Except as provided in paragraph (2), if* an individual breaches his written contract by failing (for any reason) either to begin such individual's service obligation in accordance with section 752 or 753 or to complete such service obligation, the United States shall be entitled to recover from the individual an amount determined in accordance with the formula

$$A = 3\phi(t - s/t)$$

in which "A" is the amount the United States is entitled to recover, "ϕ" is the sum of the amounts paid under this subpart to or on behalf of the individual and the interest on such amounts which would be payable if at the same time the amounts were paid they were loans bearing interest at the maximum legal prevailing rate, as determined by the Treasurer of the United States; "t" is the total number of months in the individual's period of obligated service; and "s" is the number of months of such period served by him in accordance with section 752 or a written agreement under section 753. Any amount of damages which the United States is entitled to recover under this subsection shall, within the one year period beginning on the date of the breach of the written contract, be paid to the United States.

(2) If an individual is released under section 753 from a service obligation under section 225 (as in effect on September 30, 1977) and if the individual does not meet the service obligation incurred under section 753, subsection (f) of such section 225 shall apply to such individual in lieu of paragraph (1) of this subsection.

* * * * * * *

AUTHORIZATION OF APPROPRIATIONS

SEC. 756. (a) There are authorized to be appropriated for scholarships under this subpart $75,000,000 for the fiscal year ending September 30, 1978, $140,000,000 for the fiscal year ending September 30, 1979, [and] $200,000,000 for the fiscal year ending September 30, 1980, *$92,000,000 for the fiscal year ending September 30, 1981, $101,000,000 for the fiscal year ending September 30, 1982, and $109,000,000 for the fiscal year ending September 30, 1983.* For the fiscal year ending September 30, [1981;]*1984*, and for each of the two succeeding fiscal years, there are authorized to be appropriated such sums as may be necessary to continue to make scholarship awards to students who have entered into written contracts under the Scholarship Program before October 1, [1980] *1983*.

* * * * * * *

Subpart V—Other Scholarships

SCHOLARSHIPS FOR FIRST-YEAR STUDENTS OF EXCEPTIONAL FINANCIAL NEED

SEC. 758. (a) The Secretary shall make grants to a public or nonprofit school of medicine, osteopathy, dentistry, optometry, pharmacy, podiatry, or veterinary medicine which is accredited as provided in section 721(b)(1)(B), for scholarships to be awarded by the school to full-time students thereof who are of exceptional financial need and who are in their first *or second* year of study at such school.

(b)(1) Scholarships may be awarded by a school from a grant under subsection (a) only to individuals who have been accepted by it for enrollment as full-time students in their first *or second* year of study at such school.

(2) A scholarship awarded to a student for a school year under a grant made under subsection (a) shall be the scholarship described in section 751(g).

(3) For purposes of this section, the term "first *or second* year of study" means, with respect to a student of a school other than a school of pharmacy, the student's first *or second* year of postbaccalaureate study at such school.

(c) The Secretary shall [distribute grants under this section among all schools of the health professions, but shall] give priority in distributing [such] grants *under subsection (a)* ot schools of medicine, osteopathy, and dentistry.

(d) For the purpose of making grants under this section, there is authorized to be appropriated $16,000,000 for the fiscal year ending September 30, 1978, $17,000,000 for the fiscal year ending September 30, 1979, [and] $18,000,000 for the fiscal year ending September 30, 1980, *$30,000,000 for the fiscal year ending September 30, 1981, $40,000,000 for the fiscal year ending September 30, 1982, and $50,000,000 for the fiscal year ending September 30, 1983.*

PART E—GRANTS TO IMPROVE THE QUALITY OF SCHOOLS OF MEDICINE, OSTEOPATHY, DENTISTRY, [PUBLIC HEALTH,] VETERINARY MEDICINE, OPTOMETRY, PHARMACY, AND PODIATRY

[CAPITATION GRANTS]

INSTITUTIONAL SUPPORT

[SEC. 770. (a) GRANT COMPUTATION.—The Secretary shall make annual grants to schools of medicine, osteopathy, dentistry, public health, veterinary medicine, optometry, pharmacy, and podiatry for the support of the education programs of such schools. The amount of the annual grant to each such school with an approved application shall be computed for each fiscal year as follows:

[(1) Each school of medicine, osteopathy, and dentistry shall receive—

[(A) for the fiscal year ending September 30, 1978, $2,000 for each full-time student enrolled in such school in the school year beginning in such fiscal year,

[(B) for the fiscal year ending September 30, 1979, $2,050 for each full-time student enrolled in such school in the school year beginning in such fiscal year, and

[(C) for the fiscal year ending September 30, 1980, $2,100 for each full-time student enrolled in such school in the school year beginning in such fiscal year.

[(2) (A) Each school of public health shall receive for the fiscal year ending September 30, 1978, and for each of the next two fiscal years an amount equal to the product of—

[(i) $1,400, and

[(ii) the sum of (I) the number of full-time students enrolled in such school in the school year beginning in such fiscal year, and (II) the number of full-time equivalents of part-time students, determined pursuant to subparagraph (B), for such school for such school year.

[(B) For purposes of subparagraph (A) the number of full-time equivalents of part-time students for a school of public health for any school year is a number equal to—

[(i) the total number of credit hours of instruction in such year for which part-time students of such school, who are pursuing a course of study leading to a graduate degree in public health or an equivalent degree, have enrolled, divided by

[(ii) the greater of (I) the number of credit hours of instruction which a full-time student of such school was required to take in such year, or (II) 9,

rounded to the the next highest whole number.

[(3) For the fiscal year ending September 30, 1978, and for each of the next two fiscal years, each school of veterinary

medicine shall receive $1,450 for each full-time student enrolled in such school in the school year beginning in such fiscal year.

[(4) For the fiscal year ending September 30, 1978, and for each of the next two fiscal years, each school of optometry shall receive $765 for each full-time student enrolled in such school in the school year beginning in such fiscal year.

[(5) For the fiscal year ending September 30, 1978, and for each of the next two fiscal years, each school of pharmacy (other than a school of pharmacy with a course of study of more than four years) shall receive $695 for each full-time student enrolled in such school in the school year beginning in such fiscal year. Each school of pharmacy with a course of study of more than four years shall receive $695 for each full time student enrolled in the last four years of such school. For purposes of section 771, a student enrolled in the first year of the last four years of such school shall be considered a first-year student.

[(6) For the fiscal year ending September 30, 1978, and for each of the next two fiscal years, each school of podiatry shall receive $965 for each full-time student enrolled in such school in the school year beginning in such fiscal year.]

Sec. 770. (a) Grant Computation.—The Secretary shall make annual grants to schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, pharmacy, and podiatry for the support of the education programs of such schools. The amount of the annual grant to each such school with an approved application shall be computed for each fiscal year as follows:

(1) Each school of medicine, osteopathy, and dentistry shall receive—

(A) for the fiscal year ending September 30, 1981, $2,000 for each full-time student enrolled in such school in the school year beginning in such fiscal year;

(B) for the fiscal year ending September 30, 1982, $1,000 for each full-time student enrolled in such school in the school year beginning in such fiscal year; and

(C) for the fiscal year ending September 30, 1983, $500 for each full-time student enrolled in such school in the school year beginning in such fiscal year.

(2) Each school of veterinary medicine shall receive—

(A) for the fiscal year ending September 30, 1981, $1,200 for each full-time student enrolled in such school in the school year beginning in such fiscal year;

(B) for the fiscal year ending September 30, 1982, $600 for each full-time student enrolled in such school in the school year beginning in such fiscal year; and

(C) for the fiscal year ending September 30, 1983, $300 for each full-time student enrolled in such school in the school year beginning in such fiscal year.

(3) Each school of optometry shall receive—

(A) for the fiscal year ending September 30, 1981, $700 for each full-time student enrolled in such school in the school year beginning in such fiscal year;

(B) for the fiscal year ending September 30, 1982, $350 for each full-time student enrolled in such school in the school year beginning in such fiscal year; and

(C) for the fiscal year ending September 30, 1983, $100 for each full-time student enrolled in such school in the school year beginning in such fiscal year.

(4) Each school of pharmacy shall receive—

(A) for the fiscal year ending September 30, 1981, $600 for each full-time student enrolled in the last four years of such school in the school year beginning in such fiscal year;

(B) for the fiscal year ending September 30, 1982, $300 for each full-time student enrolled in the last four years of such school in the school year beginning in such fiscal year; and

(C) for the fiscal year ending September 30, 1983, $100 for each full-time student enrolled in the last four years of such school in the school year beginning in such fiscal year.

(5) Each school of podiatry shall receive—

(A) for the fiscal year ending September 30, 1981, $600 for each full-time student enrolled in such school in the school year beginning in such fiscal year;

(B) for the fiscal year ending September 30, 1982, $400 for each full-time student enrolled in such school in the school year beginning in such fiscal year; and

(C) for the fiscal year ending September 30, 1983, $200 for each full-time student enrolled in such school in the school year beginning in such fiscal year.

(b) APPORTIONMENT OF APPROPRIATIONS.—Notwithstanding subsection (a), if the aggregate of the amounts of the grants to be made in accordance with such subsection for any fiscal year to schools of either medicine, osteopathy, dentistry, [public health.] veterinary medicine, optometry, pharmacy, or podiatry with approved applications exceeds the total of the amounts appropriated for such category of schools under the appropriate paragraph of subsection (e) for such grants, the amount of a school's grant with respect to which such excess exists shall for such fiscal year be an amount which bears the same ratio to the amount determined for the school under subsection (a) as the total of the amounts appropriated for that year under the appropriate paragraph of subsection (e) for grants to schools of the same category as such school bears to the amount required to make grants in accordance with subsection (a) to each of the schools of that category with approved applications.

(c) ENROLLMENT DETERMINATIONS.—

(1) For purposes of this section, regulations of the Secretary shall include provisions relating to the determination of the number of students enrolled in a school or in a particular year-class in a school on the basis of estimates, on the basis of the number of students who in an earlier year were enrolled in a school or in a particular year-class, or on such other basis as he deems appropriate for making such determination and shall include methods of making such determination when a school or a year-class was not in existence in an earlier year at a school.

(2) For purposes of this section, the term "full-time students" (whether such term is used by itself or in connection with a particular year-class) means students pursuing a full-time course of study leading to a degree of doctor of medicine, doctor of dentistry or an equivalent degree, doctor of osteopathy, bachelor or master of science in pharmacy or an equivalent degree, doctor of optometry or an equivalent degree, doctor of veterinary medicine or an equivalent degree, or doctor of podiatry or an equivalent degree, [or to a graduate degree in public health or equivalent degree]. In the case of a training program of a school designed to permit the students enrolled in such program to complete, with six years after completing secondary school, the requirements for degree of doctor of medicine, doctor of dentistry or an equivalent degree, or doctor of osteopathy, the term "full-time students" shall only include students enrolled on a full-time basis in the last four years of such program and for purposes of section 771, students enrolled in the first of the last four years of such programs shall be considered as first-year students.

[(d) APPLICATIONS FOR NEW SCHOOLS.—In the case of a new school of medicine, osteopathy, dentistry, public health, veterinary medicine, optometry, pharmacy, or podiatry, which applies for a grant under this section in the fiscal year preceding the fiscal year in which it will admit its first class the enrollment for purposes of subsection (a) shall be the number of full-time students which the Secretary determines, on the basis of assurances provided by the school, will be enrolled in the school, in the fiscal year after the fiscal year in which the grant is made.]

[(e) AUTHORIZATIONS OF APPROPRIATIONS.—

[(1) There are authorized to be appropriated $124,182,000 for the fiscal year ending September 30, 1978, $131,683,800 for the fiscal year ending September 30, 1979, and $139,400,100 for the fiscal year ending September 30, 1980, for payments under grants under the section to schools of medicine.

[(2)There are authorized to be appropriated $8,680,000 for the fiscal year ending September 30, 1978, $9,337,750 for the fiscal year ending September 30, 1979, and $10,159,800 for the fiscal year ending September 30, 1980, for payments under grants under this section for schools of osteopathy.

[(3) There are authorized to be appropriated $43,798,000 for the fiscal year ending September 30, 1978, $45,409,550 for the fiscal year ending September 30, 1979, and $46,909,800 for the fiscal year ending September 30, 1980, for payments under grants under this section for schools of dentistry.

[(4) There are authorized to be appropriated $9,739,800 for the the fiscal year ending September 30, 1978, $10,462,200 for the fiscal year ending September 30, 1979, and $11,060,000 for the fiscal year ending September 30, 1980, for payments under grants under this section to schools of public health.

[(5) There are authorized to be appropriated $10,219,600 for the fiscal year ending September 30, 1978, $10,548,750 for the fiscal year ending September 30, 1979, and $10,705,350 for the fiscal year

ending September 30, 1980, for payments under grants under this section to schools of veterinary medicine.

[(6) There are authorized to be appropriated $3,204,585 for the fiscal year ending September 30, 1978, $3,272,670 for the fiscal year ending September 30, 1979, and $3,366,000 for the fiscal year ending September 30, 1980, for payments under grants under this section to schools of optometry.

[(7) There are authorized to be appropriated $16,989,970 for the fiscal year ending September 30, 1978, $17,110,205 for the fiscal year ending September 30, 1979, and $17,368,050 for the fiscal year ending September 30, 1980, for payments under grants under this section to schools of pharmacy.

[(8) There are authorized to be appropriated $2,267,750 for the fiscal year ending September 30, 1978, $2,270,645 for the fiscal year ending September 30, 1979, and $2,285,120 for the fiscal year ending September 30, 1980, for payments under grants under this section to schools of podiatry.]

(*d*) *Authorizations of Appropriations.*—

(1) There are authorized to be appropriated $37,259,000 for the fiscal year ending September 30, 1981, $24,836,000 for the fiscal fiscal year ending September 30, 1981, $1,936,000 for the fiscal year ending September 30, 1983, for payments under grants under this section to schools of medicine.

(2) There are authorized to be appropriated $2,904,000 for the fiscal year ending September 30, 1981, $1,936,000 for the fiscal year ending September 30, 1982, and $968,000 for the fiscal year ending September 30, 1983, for payments under grants under this section for schools of osteopathy.

(3) There are authorized to be appropriated $12,148,000 for the fiscal year ending September 30, 1981, $8,099,000 for the fiscal year ending September 30, 1982, and $4,049,000 for the fiscal year ending September 30, 1983, for payments under grants under this section for schools of dentistry.

(4) There are authorized to be appropriated $2,700,000 for the fiscal year ending September 30, 1981, $1,800,000 for the fiscal year ending September 30, 1982, and $900,000 for the fiscal year ending September 30, 1983, for payments under grants under this section to schools of veterinary medicine.

(5) There are authorized to be appropriated $794,000 for the fiscal year ending September 30, 1981, $529,000 for the fiscal year ending September 30, 1982, and $265,000 for the fiscal year ending September 30, 1983, for payments under grants under this section to schools of optometry.

(6) There are authorized to be appropriated $4,538,300 for the fiscal year ending September 30, 1981, $3,025,000 for the fiscal year ending September 30, 1982, and $1,513,000 for the fiscal year ending September 30, 1983, for payments under grants under this section to schools of pharmacy.

(7) There are authorized to be appropriated $609,000 for the fiscal year ending September 30, 1981, $406,000 for the fiscal year ending September 30, 1982, and $203,000 for the fiscal year ending September 30, 1983, for payments under grants under this section to schools of podiatry.

ELIGIBILITY FOR CAPITATION GRANTS

SEC. 771. [295f–1] (a) IN GENERAL.—The Secretary shall not make a grant under section 770 to any school in a fiscal year beginning after September 30, 1977, unless the application for the grant contains, or is supported by, assurances satisfactory to the Secretary that—

(1) the first-year enrollment of full-time students in the school in the school year beginning in the fiscal year in which the grant applied for is to be made will not be less than the first-year enrollment (*determined without regard to any increase in such enrollment made by the school to enable it to qualify for financial assistance under chapter 82 of title 38, United States Code*)[1] of such students in the school in the preceding school year or in the school year beginning in the fiscal year ending September 30, 1976, whichever is greater; and

(2) the applicant will expend in carrying out its functions as a school of medicine, osteopathy, dentistry, public health, veterinary medicine, optometry, pharmacy, or podiatry, as the case may be, during the fiscal year for which such grant is sought, an amount of funds (other than funds for construction as determined by the Secretary) from non-Federal sources which is at least as great as the amount of funds expended by such applicant for such purpose (excluding expenditures of a nonrecurring nature) in the fiscal year preceding the fiscal year for which such grant is sought.

ELIGIBILITY FOR [CAPITATION GRANTS] *INSTITUTIONAL SUPPORT*

[SEC. 771. (a) IN GENERAL.—The Secretary shall not make a grant under section 770 to any school in a fiscal year beginning after September 30, 1977, unless the application for the grant contains, or is supported by, assurances satisfactory to the Secretary that—

[(1) the first-year enrollment of full-time students in the school year beginning in the fiscal year in which the grant applied for is to be made will not be less than the first-year enrollment of such students in the school in the preceding school year or in the school year beginning in the fiscal year ending September 30, 1976, whichever is greater; and

[(2) the applicant will expend in carrying out its functions as a school of medicine, osteopathy, dentistry, public health, veterinary medicine, optometry, pharmacy, or podiatry, as the case may be, during the fiscal year for which such grant is sought, an amount of funds (other than funds for construction as determined by the Secretary) from non-Federal sources which is at least as great as the amount of funds expended by such applicant for such purpose (excluding expenditures of a nonrecurring nature) in the fiscal year preceding the fiscal year for which such grant is sought.]

SEC. 771. (a) IN GENERAL.—

(1) The Secretary shall not make a grant under section 770(a) to any school in a fiscal year beginning after September 30, 1980, unless the application for the grant contains, or is supported by, assurances satisfactory to the Secretary that the applicant will

[1] Effective for fiscal year 1980 only.

expend in carrying out its functions as a school of medicine, osteopathy, dentistry, veterinary medicine, optometry, pharmacy, or podiatry, as the came may be, during the fiscal year for which such grant is sought, an amount of funds (other than funds for construction as determined by the Secretary) from non-Federal sources which is at least as great as the amount of funds expended by such applicant for such purpose (excluding expenditures of a nonrecurring nature) in the fiscal year preceding the fiscal year for which such grant is sought.

(2) If in any fiscal year the amount appropriated under subsection (d) of section 770 for grants under subsection (a) of such section for a category of schools is less than the amount appropriated for the fiscal year ending September 30, 1980, for such grants, then in the fiscal year in which the appropriations are less, no grant may be made under subsection (a) of section 770 to any school in such category which did not receive such a grant in the fiscal year ending September 30, 1980.

(b) (1) MEDICAL SCHOOLS.—To be eligible for a grant under section 770 each school of medicine shall, in addition to the requirements of subsection (a), meet the applicable requirements of [paragraphs (2) and (3)] *paragraph* (2).

* * * * * * *

[(3) (A) Except as provided under subparagraph (D), a school of medicine may not receive a grant under section 770 to be made in the fiscal year ending September 30, 1978, unless its application for such grant contains or is supported by assurances satisfactory to the Secretary that such school will increase its enrollment of full-time, third-year students as prescribed by subparagraph (B).

[(B) The enrollment increase referred to in subparagraph (A) is an enrollment increase in a school of medicine—

[(i) which is to occur in school year 1978–1979,

[(ii) in the number of full-time, third-year students over the number of full-time, second-year students who successfully completed the second-year program of such school in the preceding school year and enrolled in the third-year class of such school, and

[(iii) which is not less than 5 per centum of the number of—

[(I) full-time, first-year students enrolled in such school in school year 1977–1978, or

[(II) full-time, third-year students enrolled in such school in school year 1977–1978,

whichever is less.

[(C) In determining the number of full-time, third-year students enrolled in a school in a school year in which an increase is required by subparagraph (B) (i)—

[(i) full-time, third-year students of such school who were not second-year students in such school and—

[(I) who are not citizens of the United States,

[(II) who were previously enrolled in a school of medicine to which the requirement of subparagraph (A) applies,

[(III) who were previously enrolled in a school of medicine to which the requirement of subparagraph (A) does not apply because of subparagraph (D) and for whom a position in the third-year class of such school was available in such school year,

[(IV) who first enrolled after October 12, 1976, in a school of medicine not in a State.

[(V) who were previously enrolled in a school of dentistry or a school of osteopathy, or

[(VI) who were previously enrolled in a school of medicine which is in a State and which is not accredited by the body or bodies approved for such purpose by the Commissioner of Education,

shall not be counted; and

[(ii) full-time, second-year students enrolled in such year who are citizens of the United States and who were first enrolled before October 12, 1976, in a school of medicine not in a State shall be counted as third-year students.

[(D) The Secretary may waive (in whole or in part) the requirement of subparagraph (A) for a school of medicine—

[(i) if the Secretary determines, after receiving the written recommendation of the appropriate accreditation body or bodies (approved for such purpose by the Commissioner of Education) that compliance by such school with such requirement will prevent it from maintaining its accreditation;

[(ii) upon a finding that, because of the inadequate size of the population served by the hospital or clinical facility in which such school conducts its clinical training, an increase in its enrollment of third-year students to meet such requirement will prevent it from providing high quality clinical training for each of its third year students; or

[(iii) if the Secretary determines that such school has made a good faith effort to meet the requirement of subparagraph (A) but has been unable to meet such requirement solely because there is an insufficient number of students who, under this paragraph, are eligible to be counted in determining if the school has met such requirement.

The requirement of subparagraph (A) does not apply to the application of a school of medicine for a grant under section 770 if in school year 1977–1978 such school had an enrollment of full-time, first-year students which exceeded its enrollment in such school year of full-time, third-year students by at least 25 per centum.

[(E) A school of medicine which did not receive a grant under section 770 because it did not comply with the applicable requirements of this paragraph shall not be eligible to receive a grant under such section to be made in the fiscal year ending September 30, 1979, or in the next fiscal year.]

* * * * * * *

[(e) SCHOOLS OF PUBLIC HEALTH.—(1) To be eligible for a grant under section 770 for a fiscal year beginning after September 30, 1977, a school of public health shall, in addition to the requirements of

subsection (a), maintain an enrollment of full-time, first-year students, for the school year beginning in the fiscal year ending September 30, 1978, and for each school year thereafter beginning in a fiscal year for which a grant under section 770 is applied for, which exceeds the number of full-time, first-year students enrolled in such school in the school year beginning in the fiscal year ending September 30, 1976—

[(A) by 5 percent of such number if such number was not more than 100, or

[(B) by 2.5 percent of such number, or 5 students, whichever is greater, if such number was more than 100.

[(2) The Secretary may waive (in whole or in part) application to a school of public health of the requirement of paragraph (1) if the Secretary determines, after receiving the written recommendation of the appropriate accreditation body or bodies (approved for such purpose by the Commissioner of Education) that compliance by such school with such requirement will prevent it from maintaining its accreditation.]

[(f)] (*e*) SCHOOLS OF VETERINARY MEDICINE.—(1) To be eligible for a grant under section 770 for a fiscal year beginning after September 30, 1977, a school of veterinary medicine shall, in addition to the requirements of subsection (a), meet the requirements of paragraph (2) and paragraph (3) or (4).

(2) An application of a school of veterinary medicine for a grant under section 770 shall contain or be supported by assuranecs satisfactory to the Secretary that the clinical training of the school shall emphasize predominantly care to food-producing animals or to fibre-producing animals, or to both types of animals.

(3) A school of veterinary medicine shall maintain an enrollment of full-time, first-year students, for the school year beginning in the fiscal year ending September 30, 1978, and for each school year thereafter beginning in a fiscal year for which a grant under section 770 is applied for, which exceeds the number of full-time, first-year students enrolled in such school in the school year beginning in the fiscal year ending September 30, 1976—

(A) by 5 percent of such number if such number was not more than 100, or

(B) by 2.5 percent of such number, or 5 students, whichever is greater, if such number was more than 100.

(4) An application of a school of veterinary medicine shall contain or be supported by assurances satisfactory to the Secretary that for the school year beginning in the fiscal year for which a grant is made under section 770 at least 30 percent of the enrollment of full-time, first-year students in such school will be comprised of students who are residents of States in which there are no accredited schools of veterinary medicine.

[(g)](*f*) SCHOOLS OF OPTOMETRY.—(1) To be eligible for a grant under section 770 for a fiscal year beginning after September 30, 1977, a school of optometry shall, in addition to the requirements of subsection (a), meet the requirement of paragraph (2) or (3).

(2) A school of optometry shall maintain an enrollment of full-time, first-year students, for the school year beginning in the fiscal

year ending September 30, 1978, and for each school year thereafter beginning in a fiscal year for which a grant under section 770 is applied for, which exceeds the number of full-time, first-year students enrolled in such school in the school year beginning in the fiscal year ending September 30, 1976—

(A) by 5 percent of such number if such number was not more than 100, or

(B) by 2.5 percent of such number, or 5 students, whichever is greater, if such number was more than 100.

(3) An application of a school of optometry shall contain or be supported by assurances satisfactory to the Secretary that for the school year beginning in the fiscal year for which a grant is made under section 770 at least 25 percent [(or 50 percent if the applicant is a nonprofit private school of optometry) of the first-year enrollment of full-time students in such school will be comprised of students who are residents of States in which there are no accredited schools of optometry].

[(h)](*g*) SCHOOLS OF PODIATRY.—(1) To be eligible for a grant under section 770 for a fiscal year beginning after September 30, 1977, a school of podiatry shall, in addition to the requirements of subsection (a), meet the requirements of paragraph (2) or (3).

(2) A school of podiatry shall maintain an enrollment of full-time, first-year students, for the school year beginning in the fiscal year ending September 30, 1978, and for each school year thereafter beginning in a fiscal year for which a grant under section 770 is applied for, which exceeds the number of full-time, first-year students enrolled in such school in the school year beginning in the fiscal year ending September 30, 1976—

(A) by 5 percent of such number if such number was not more than 100, or

(B) by 2.5 percent of such number, or 5 students, whichever is greater, if such number was more than 100.

(3) An application of a school of podiatry shall contain or be supported by assurances satisfactory to the Secretary that for the school year beginning in the fiscal year for which a grant is made under section 770, at least 40 percent of the enrollment of full-time, first-year students in such school will be comprised of students who are residents of States in which there are no accredited schools of podiatry.

[(i)](*h*) SCHOOLS OF PHARMACY.—To be eligible for a grant under section 770 for a fiscal year beginning after September 30, 1977, a school of pharmacy's application for such a grant shall, in addition to the assurances required by subsection (a), contain or be supported by assurances that each student who is enrolled in the school will before graduation undergo a training program in clinical pharmacy, which shall include (1) an inpatient and outpatient clerkship experience in a hospital, extended care facility, or other clinical setting; (2) interaction with physicians and other health professionals; (3) training in the counseling of patients with regard to the appropriate use of and reactions to drugs; and (4) training in drug information retrieval and analysis in the context of actual patient problems.

APPLICATIONS FOR [CAPITATION, START-UP, SPECIAL PROJECT, AND FINANCIAL DISTRESS GRANTS] *INSTITUTIONAL SUPPORT*

SEC. 772. (a) The Secretary may from time to time set dates (not earlier than in the fiscal year preceding the year for which a grant is sought) by which applications for grants under section 770 for any fiscal year must be filed.

(b) To be eligible for a grant under section 770 [or subsection (a) or (b) of section 788] the applicant must (1) be a public or other nonprofit school of medicine, osteopathy, dentistry, [public health,] veterinary medicine, optometry, pharmacy, or podiatry, and (2) be accredited by a recognized body or bodies approved for such purpose by the Commissioner of Education, except that the requirement of this clause shall be deemed to be satisfied if (A) in the case of a school which by reason of no, or on an insufficient, period of operation is not, at the time of application for a grant under this part, eligible for such accreditation, the Commissioner finds, after consultation with the appropriate accreditation body or bodies, that there is reasonable assurance that the school will meet the accreditation standards of such body or bodies prior to the beginning of the academic year following the normal graduation date of students who are in their first year of instruction at such school during the fiscal year in which the Secretary makes a final determination as to approval of the application, or (B) in the case of any other school, the Commissioner finds after such consultation and after consultation with the Secretary that there is reasonable ground to expect that, with the aid of a grant (or grants) under those sections, having regard for the purposes of the grant for which application is made, such school will meet such accreditation standards within a reasonable time.

(c) The Secretary shall not approve or disapprove any application for a grant under section 770 except after consultation with the National Advisory Council on Health Professions Education (established by section 725).

(d) A grant under section 770 may be made only if the application therefor—

(1) is approved by the Secretary upon his determination that the applicant (and its application) meet the applicable eligiblity conditions prescribed by section 771 or subsection (b) of this section;

(2) contains such additional information as the Secretary may require to make the determinations required of him [under the section authorizing the grant for which the application is made] *under section 770* and such assurances as he may find necessary to carry out the purposes of such section; and

(3) provides for such fiscal control and accounting procedures and reports, including the use of such standard procedures for the recording and reporting of financial information, as the Secretary may prescribe, and access to the records of the applicant, as the Secretary may require to enable him to determine the costs to the applicant of its program for the education or training of students.

62-655 O - 80 - 12

Part F—Grants and Contracts for Programs and Projects

PROJECT GRANTS FOR ESTABLISHMENT OF DEPARTMENTS OF FAMILY MEDICINE

SEC. 780. (a) The Secretary may make grants to schools of medicine and osteopathy to meet the costs of projects to establish and maintain academic administrative units (which may be departments, divisions, or other units) to provide clinical instruction in family medicine.

(b) The Secretary may not approve an application for a grant under subsection (a) unless such application contains—

(1) assurance satisfactory to the Secretary that the academic administrative unit with respect to which the application is made will (A) be comparable to academic administrative units for other major clinical specialties offered by the applicant, (B) be responsible for directing an amount of the curriculum for each member of the student body engaged in an education program leading to the awarding of the degree of doctor of medicine or doctor of osteopathy which amount is determined by the Secretary to be comparable to the amount of curriculum required for other major clinical specialties in the school, (C) have a number of full-time faculty which is determined by the Secretary to be sufficient to conduct the instruction required by clause (B) and to be comparable to the number of faculty assigned to other major clinical specialties in the school, and (D) have control over *or affiliation with* a three-year approved or provisionally approved residency training program in family practice or its equivalent as determined by the Secretary which shall have the capacity to enroll a total of no less than twelve interns or residents per year; and

(2) such other information as the Secretary shall by regulation prescribe.

(c) There are authorized to be appropriated $10,000,000 for the fiscal year ending September 30, 1978, $15,000,000 for the fiscal year ending September 30, 1979, [and] $20,000,000 for the fiscal year ending September 30, 1980, *$15,000,000 for the fiscal year ending September 30, 1981, $20,000,000 for the fiscal year ending September 30, 1982, and $25,000,000 for the fiscal year ending September 30, 1983*, for payments under grants under subsection (a).

AREA HEALTH EDUCATION CENTERS

[SEC. 781. (a) For the purpose of improving the distribution, supply, quality, utilization, and efficiency of health personnel in the health services delivery system and for the purpose of encouraging the regionalization of education responsibilities of health professions schools, the Secretary may enter into contracts for projects to assist in the planning, development, and operation of area health education center programs.]

SEC. 781. (a)(1) The Secretary may enter into contracts with schools of medicine and osteopathy for the planning, development, and operation of area health education center programs.

(2) The Secretary may enter into contracts with schools of medicine and osteopathy, which have previously entered into contracts under this section, to carry out under area health education center programs—

(A) projects to improve the distribution, supply, quality, utilization, and efficiency of health personnel in the health services delivery system;

(B) projects to encourage the regionalization of education responsibilities of the health professions schools; and

(C) projects designed to prepare, through preceptorships and other programs, individuals subject to a service obligation under the National Health Service Corps Scholarship Program to effectively provide health services in health manpower shortage areas.

* * * * * * *

(c) Each medical or osteopathic school participating in an area health education center program shall—

(1) provide for the active participation in such program by individuals who are associated with the administration of the school and each of the departments (or specialties if the school has no such departments) of internal medicine, pediatrics, obstetrics and gynecology, surgery, psychiatry, and family medicine;

(2) provide that no less than 10 percent of all undergraduate medical or osteopathic clinical education of the school will be conducted in an area health education center and at locations under the sponsorship of such center;

(3) be responsible for, or conduct, a program for the training of physician assistants (as defined in section 701(7)) or nurse practitioners (as defined in section 822) which gives special consideration to the enrollment of individuals from, or intending to practice in, the area served by the area health education center of the program; and

(4) provide for the active participation of at least 2 schools or programs of other health professions (including a school of dentistry if there is one affiliated with the university with which the school of medicine or osteopathy is affiliated) in the educational program conducted in the area served by the area health education center.

The requirement of paragraph *(2)* or (3) shall not apply to a medical or osteopathic school participating in an area health education center program if another such school participating in the same program meets the requirement of that paragraph.

(d)(1) Each area health education center shall specifically designate a geographic area in which it will serve, or shall specifically designate a medically underserved population it will serve (such area or population with respect to such center in this section referred to as "the area served by the center"), which area or population is in a location remote from the main site of the teaching facilities of the school or schools which participate in the program with such center.

(2) Each area health education center shall—

(A) provide for or conduct training in health education services, including education in nutrition evaluation and counseling, in the area served by the center;

(B) assess the health manpower needs of the area served by the center and assist in the planning and development of training programs to meet such needs;

(C) provide for or conduct a medical residency training program in family medicine, general internal medicine, or general pediatrics in which no fewer than six individuals are enrolled in first-year positions in such program;

(D) provide opportunities for continuing medical education (including education in disease prevention) to all physicians and other health professionals (including allied health personnel) practicing within the area served by the center;

(E) provide continuing medical education and other *educational* support services to the National Health Service Corps members serving within the area served by the center;

(F) encourage the utilization of nurse practitioners and physician assistants within the area served by the center and the recruitment of individuals for training in such professions at the participating medical or osteopathic schools;

(G) arrange and support educational opportunities for medical and other students at health facilities, ambulatory care centers, and health agencies throughout the area served by the center; and

(H) have an advisory board of which at least 75 percent of the members shall be individuals, including both health service providers and consumers, from the area served by the center.

Any area health education center which is participating in an area health education center program in which another center has a medical residency training program described in subparagraph (C) need not provide for or conduct such a medical residency training program.

(e) [The Secretary is authorized to enter into contracts with medical and osteopathic schools, which have cooperative arrangements with area health education centers, for the planning, development, and operation of area health education center programs.] In entering into contracts under this section the Secretary shall assure that—

(1) at least 75 percent of the total funds provided to any school shall be expended by an area health education center program in the area health education centers;

(2) not more than 75 percent of the total operating funds of a program in any year shall be provided by the Secretary; and

(3) no contract shall provide funds solely for the planning or development of such a program for a period of longer than two years.

(f) [For the purpose of this section the term "area health education center program" means a program which is organized and operated in a manner described in subsection (b) and which is capable, as determined by the Secretary, of performing each of the functions described in subsection (d)(2).] *For purposes of this section, the term "area health education center program" means a program which is organized as provided in subsection (b) and under which the participating medical and osteopathic schools and the area health education centers meet the requirements of subsections (c) and (d).* The Secre-

tary shall, by regulation, establish standards and criteria for the requirements of this section.

(g) There are authorized to be appropriated to carry out the provisions of this section $20,000,000 for the fiscal year ending September 30, 1978, $30,000,000 for the fiscal year ending September 30, 1979, [and] $40,000,000 for the fiscal year ending September 30, 1980, *$21,000,000 for the fiscal year ending September 30, 1981, $28,000,000 for the fiscal year ending September 30, 1982, and $30,000,000 for the fiscal year ending September 30, 1983. The Secretary may obligate not more than 10 percent of the amount appropriated under this subsection for any fiscal year for contracts under subsection (a)(2).*

* * * * * * *

PROGRAMS FOR PHYSICIAN ASSISTANTS, EXPANDED FUNCTION DENTAL AUXILIARIES AND DENTAL TEAM PRACTICE

SEC. 783. (a) The Secretary may make grants to and enter into contracts with public or nonprofit private schools of medicine, osteopathy, and dentistry and other public or nonprofit private entities to meet the costs of projects to—

(1) plan, develop, and operate or maintain programs for the training of physician assistants (as defined in section 701(7));

(2) plan, develop, and operate or maintain programs for the training of expanded function dental auxiliaries (as defined in section 701(8)); and

(3) plan, develop, and operate or maintain a program to train dental students in the organization and management of multiple auxiliary dental team practice in accordance with regulations of the Secretary.

(b) No grant or contract may be made under subsection (a) unless the application therefor contains or is supported by assurances satisfactory to the Secretary that the school or entity receiving the grant or contract has appropriate mechanisms for placing graduates of the training program with respect to which the application is submitted, in positions for which they have been trained.

(c) The Secretary shall ensure that the making of grants and entering into contracts under this section shall be integrated with the making of grants and entering into contracts under section [830.] *822.*

(d) The costs for which a grant or contract under this section may be made include costs of preparing faculty members to teach in programs for the training of physician assistants and expanded function dental auxiliaries.

(e) For payments under grants and contracts under this section, there is authorized to be appropriated $25,000,000 for the fiscal year ending September 30, 1978, $30,000,000 for the fiscal year ending September 30, 1979, [and] $35,000,000 for the fiscal year ending September 30, 1980, *$14,000,000 for the fiscal year ending September 30, 1981, $15,000,000 for the fiscal year ending September 30, 1982, and $16,000,000 for the fiscal year ending September 30, 1983.*

GRANTS FOR TRAINING, TRAINEESHIPS, AND FELLOWSHIPS IN GENERAL INTERNAL MEDICINE AND GENERAL PEDIATRICS

SEC. 784. (a) The Secretary may make grants to and enter into contracts with schools of medicine and osteopathy, *public or private nonprofit hospital, or any other public or private nonprofit entity* to meet the costs of projects—

(1) to plan, develop, and operate approved residency training programs in internal medicine or pediatrics, which emphasize the training of residents for the practice of general internal medicine or general pediatrics (as defined by the Secretary in regulations); [and]

(2) which provide financial assistance (in the form of traineeships and fellowships) to residents who are participants in any such program, and who plan to specialize or work in the practice of general internal medicine or general pediatrics];

(3) to plan, develop, and operate programs for the training of physicians who plan to teach in general internal medicine and general pediatrics training programs; and

(4) to provide assistance (in the form of traineeships and fellowships) to physicians who are participants in any such program.

(b) There are authorized to be appropriated to carry out the provisions of this section $10,000,000 for the fiscal year ending September 30, 1977, $15,000,000 for the fiscal year ending September 30, 1978, $20,000,000 for the fiscal year ending September 30, 1979, [and] $25,000,000 for the fiscal year ending September 30, 1980, *$23,000,000 for the fiscal year ending September 30, 1981, $30,000,000 for the fiscal year ending September 30, 1982, and $32,000,000 for the fiscal year ending September 30, 1983.*

* * * * * * *

FAMILY MEDICINE AND GENERAL PRACTICE OF DENTISTRY

SEC. 786 (a) * * *

* * * * * * *

(d) There are authorized to be appropriated to make grants under this section $45,000,000 for the fiscal year ending September 30, 1978, $45,000,000 for the fiscal year ending September 30, 1979, [and] $50,000,000 for the fiscal year ending September 30, 1980, *$50,000,000 for the fiscal year ending September 30, 1981, $75,000,000 for the fiscal year ending September 30, 1982, and $80,000,000 for the fiscal year ending September 30, 1983.*

[EDUCATIONAL ASSISTANCE TO INDIVIDUALS FROM DISADVANTAGED BACKGROUNDS

[SEC. 787. (a) (1) For the purpose of assisting individuals from disadvantaged backgrounds, as determined in accordance with criteria prescribed by the Secretary, to undertake education to enter a health profession, the Secretary may make grants to and enter into contracts with schools of medicine, osteopathy, public health, dentistry, veterinary medicine, optometry, pharmacy, and podiatry and other public

or private nonprofit health or educational entities to assist in meeting the costs described in paragraph (2).

[(2) A grant or contract under paragraph (1) may be used by the health or educational entity to meet the cost of—

[(A) identifying, recruiting, and selecting individuals from disadvantaged backgrounds, as so determined, for education and training in a health profession,

[(B) facilitating the entry of such individuals into such a school,

[(C) providing counseling or other services designed to assist such individuals to complete successfully their education at such a school,

[(D) providing, for a period prior to the entry of such individuals into the regular course of education of such a school, preliminary education designed to assist them to complete successfully such regular course of education at such a school, or referring such individuals to institutions providing such preliminary education, and

[(E) publicizing existing sources of financial aid available to students in the education program of such a school or who are undertaking training necessary to qualify them to enroll in such a program.

[(b) There are authorized to be appropriated $20,000,000 for the fiscal year ending September 30, 1978, $20,000,000 for the fiscal year ending September 30, 1979, and $20,000,000 for the fiscal year ending September 30, 1980, for payments under grants and contracts under subsection (a).]

EDUCATIONAL ASSISTANCE TO INDIVIDUALS FROM DISADVANTAGED BACKGROUNDS

SEC. 787. (a) For the purpose of assisting individuals from disadvantaged backgrounds (as determined in accordance with criteria prescribed by the Secretary) to undertake education to enter a health profession, the Secretary may make grants to or enter into contracts with schools of medicine, osteopathy, dentistry, nursing, veterinary medicine, optometry, pharmacy, podiatry, or public health, institutions providing graduate programs in health administration, or other public or private nonprofit health or educational entities, to assist in meeting the cost of—

(1) establishing secondary education programs designed to increase the number of students from disadvantaged backgrounds that pursue careers in the health professions;

(2) strengthening the preprofessional curriculum of baccalaureate degree institutions predominantly attended by individuals from disadvantaged backgrounds;

(3) establishing joint programs betweeen baccalaureate degree institutions and health professions schools or other appropriate entities designed to increase the number of students from disadvantaged backgrounds in health professions schools;

(4) providing, for a period prior to the entry of such individuals into the regular course of education of health professions schools,

preliminary education designed to assist such individuals in successfully completing such regular course of education at such schools, or referring such individuals to institutions providing such preliminary education;

(5) identifying, recruiting, and selecting individuals from disadvantaged backgrounds for education and training in a health profession;

(6) facilitating the entry of such individuals into such schools;

(7) providing counseling, work-study opportunities in health service agencies, or other services designed to assist such individuals to complete successfully their education at such schools;

(8) publicizing existing sources of financial aid available to students in the education program of such school or who are undertaking training necessary to qualify to enroll in such program; or

(9) increasing the number of faculty from disadvantaged backgrounds in the health professions schools.

(b) (1) There are authorized to be appropriated for grants and contracts under this section, $30,000,000 for the fiscal year ending September 30, 1981, $33,000,000 for the fiscal year ending September 30, 1982, and $36,000,000 for the fiscal year ending September 30, 1983. Not less than 80 percent of the funds appropriated in any fiscal year shall be obligated for grants or contracts to institutions of higher education and not more than 5 percent of such funds may be obligated for grants and contracts for activities described in paragraphs (8) of subsection (a).

(2) Funds provided under grants and contracts under this section may be used to provide traineeships to students receiving the education described in subsection (a) (4) if such students would not otherwise be able to receive such education.

[PROJECT GRANT AUTHORITY FOR START-UP ASSISTANCE, FINANCIAL DISTRESS INTERDISCIPLINARY TRAINING, AND CURRICULUM DEVELOPMENT]
START-UP, CONVERSION, AND CURRICULUM GRANTS

SEC. 788. (a) (1) In the case of any new school of [medicine, osteopathy, dentistry,] public health, veterinary medicine, optometry, pharmacy, or podiatry which begins instruction after July 1, 1974, the Secretary may, after taking into account—

(A) the ability of such school to use a grant under this subsection to (i) accelerate the date it will begin instruction, or (ii) increase the number of students in its entering class, and

(B) the other resources available to such school,

make a grant to such school for each year such school is a new school (as determined under paragraph (5)). No school may receive a grant under this subsection unless the Secretary estimates that the number of full-time students enrolled in its first school year of operation will exceed twenty-three.

* * * * * * *

(3) A grant may not be made under this subsection unless an application for such grant is submitted to, and approved by, the Secretary *and the applicant meet the requirements of subsection (b) of*

section 772. The Secretary shall give priority to aplications which provide for projects which—

(A) assist in the planning, development, or initial operation of a new school of medicine, osteopathy, or dentistry (i) which will conduct exceptionally innovative programs for training students in ambulatory primary care in cooperation with accredited psychiatric practitioners or programs, as appropriate, or (ii) which will have as a major objective the provision of training opportunities for individuals from disadvantaged backgrounds;

(B) assist in the planning, development, expansion, or initial operation of a regional health profession school granting a degree in one or more of the following professions: medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, or public health; or

(C) the Secretary determines will meet a national or regional need for members of the profession to be trained in the new school for which the application is submitted.

[(b) (1) The Secretary may make grants to, and enter into contracts with schools of medicine, osteopathy, dentistry, veterinary medicine, medicine, optometry, pharmacy, podiatry, or public health for the purpose of assisting in—

[(A) (i) meeting the costs of operation of any school of medicine, osteopathy, dentistry, veterinary medicine, optometry, pharmacy, podiatry, and public health if they are in serious financial distress, or

[(ii) meeting accreditation requirements, if they have a special need to be assisted in meeting such requirements, and

[(B) carrying out appropriate operational, managerial, and financial reforms on the basis of information obtained in a comprehensive cost analysis study or nn the basis of other relevant information.

[(2) Any grant under this subsection may be made upon such terms and conditions as the Secretary determines to be reasonable and necessary, including requirements that the school agree—

[(A) to disclose any financial information or data deemed by the Secretary to be necessary to determine the sources or causes of that school's financial distress,

[(B) to conduct a comprehensive cost analysis study in cooperation with the Secretary, and

[(C) to carry out appropriate operational, managerial, and financial reforms (as the Secretary may require), including the securing of increased financial support from State or local governmental units or the increasing of tuition on the basis of information obtained in the course of a comprehensive cost analysis study or on the basis of other relevant information.

[(3) An application for a grant under this subsection must contain or be supported by assurances satisfactory to the Secretary that the applicant will expend in carrying out its function as a school of medicine, osteopathy, dentistry, veterinary medicine, optometry, pharmacy, podiatry, or public health, as the case may be, during the fiscal year for which such grant is sought an amount of funds (other than funds for construction, as determined by the Secretary) from non-

Federal sources which is at least as great as the average amount of funds expended by such applicant for such training in the preceding two years.

[(4) The Secretary may provide to any school eligible for a grant under this subsection technical assistance to enable the school to conduct a comprehensive cost analysis study of its operations, to identify operational inefficiencies, and to develop or carry out appropriate operational, managerial, and financial reforms.

[(5) The Secretary shall prepare and submit on or before October 1, 1979, a report on the administration of this subsection. Such report shall give special emphasis to a description of the results of any comprehensive cost analysis study carried out under paragraph (2)(B) and any operational, managerial, and financial reforms instituted under paragraph (2)(C).]

[(c) The Secretary may make grants to any health profession, allied health profession, or nurse training institution, or to any other public or nonprofit entity for the development of programs for cooperative interdisciplinary training among schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, pharmacy, podiatry, nursing, public health, and allied health, which emphasize—

[(1) the use of the team approach to the delivery of health services,

[(2) the training of physician assistants and nurse practitioners with physicians and expanded function dental auxiliaries with dentists, and

[(3) the training of physicians, dentists, nurses, and other health professionals in the organization, management, and effective utilization of such assistants, practitioners, and auxiliaries.]

(b)(1) The Secretary may make grants to schools which provide the first two years of education leading to the degree of doctor of medicine to assist the schools in accelerating the date they will become schools of medicine.

(2) The amount of a grant under paragraph (1) to a school shall be equal to the product of $25,000 and the number of full-time, third-year students which the Secretary estimates will enroll in the school in the school year beginning in the fiscal year in which such grant is made. Estimates by the Secretary under this paragraph of the number of full-time, third-year students to be enrolled in the school may be made on assurances provided by the school.

(3) No grant may be made under paragraph (1) unless an application for such grant is submitted to, and approved by, the Secretary. Such application shall be in such form, be submitted in such manner, and shall contain such information, as the Secretary may by regulation prescribe. To be eligible to apply for a grant under subsection (a), the applicant must be a public or nonprofit school providing the first two years of education leading to the degree of doctor of medicine and be accredited by a recognized body or bodies approved for such purpose by the Secretary of Education.

[(d)](*c*) The Secretary may make grants to and enter into contracts with any health profession, allied health profession, or nurse training institution, or any other public or nonprofit private entity for health manpower projects and programs such as—

(1) speech pathology, audiology, bioanalysis, and medical technology;

(2) establishing humanism in health care centers;

(3) biomedical combined educational programs;

(4) cooperative human behavior and psychiatry in medical and dental education and practice;

(5) bilingual health clinical training centers;

(6) curriculum development in schools of *dentistry*, optometry, pharmacy and podiatry;

(7) social work in health care;

(8) health manpower development;

(9) environmental health education and preventive medicine;

(10) the special medical problems related to women;

(11) the development or expansion of regional health professions schools;

(12) training of citizens of the United States from foreign health professions schools to enable them to enroll in residency programs in the States;

(13) psychology training programs;

(14) ethical implications of biomedical research;

(15) establishment of dietetic residencies;

(16) regional systems of continuing education;

(17) computer technology;

(18) training of professional standards review organization staff;

(19) training of health professionals in human nutrition and its application to health;

(20) health manpower development for the Trust Territories and incorporated Trust Territories of the United States; [and]

(21) training in the diagnosis, treatment, and prevention of the diseases and related medical and behavorial problems of the aged[.] *; and*

(22) training of health professionals in the diagnosis, treatment, and prevention of diabetes and other severe chronic diseases and their complications.

[(e)](*d*) (1) There are authorized to be appropriated to carry out the provisions of this section [(other than the provisions of subsections (f) and (g)] $25,000,000 for the fiscal year ending September 30, 1978, $25,000,000 for the fiscal year ending September 30, 1979, [and] $25,000,000 for the fiscal year ending September 30, 1980, *$10,000,000 for the fiscal year ending September 30, 1981, $12,500,000 for the fiscal year ending September 30, 1982, and $15,000,000 for the fiscal year ending September 30, 1983.*

[(2) From the sums authorized to be appropriated under paragraph (1) not more than—

[(A) $5,000,000 may be obligated or expended for the purposes of subsection (a), and

[(B) $10,000,000 may be obligated or expended for the purposes of subsection (b).]

(2) From the sums authorized to be appropriated under paragraph (1) not more than $5,000,000 may be obligated or expended for the purposes of subsection (a).

[(f)(1) The Secretary may make grants to any school of medicine to meet the planning costs for projects for the training of students, enrolled in the last two years of such school, in facilities—

[(A) which are other than the principal teaching facilities of such school and which are existing Federal health care facilities or are other public or private health care facilities; and

[(B) which are located in a health manpower shortage area (designated under section 332).

No grant may be made under this paragraph with respect to any project unless before the fiscal year for which the grant is to be made the project has received at least $100,000 from non-Federal sources and has been approved by the legislature of the State in which it is located.

[(2) For payments under grants under paragraph (1), there are authorized to be appropriated $400,000 for the fiscal year ending September 30, 1977.

[(g)(1) The Secretary may make grants to public and nonprofit private institutions of higher education and hospitals and other health care delivery facilities which are engaged in the development of new schools of medicine to assist such institutions and facilities in meeting the costs of employing faculty, acquiring equipment, and taking such other action related to the initial operation of a school of medicine as may be necessary for the proposed schools to meet the eligibility requirements for a grant under subsection (a) of this section.

[(2) No application for a grant under paragraph (1) may be approved by the Secretary unless the application contains or is supported by assurances satisfactory to the Secretary that—

[(A) with the assistance provided under the grant applied for the applicant will be able to accelerate the date on which the school of medicine being developed by the applicant will be able to begin its teaching program,

[(B) there is a reasonable indication of non-Federal financial resources for development and operation of such school, and

[(C) the school of medicine will emphasize training programs in family medicine and will improve access to health care for residents of the geographical regions in which such training programs are located.

The Secretary may not approve or disapprove an application submitted under this subsection unless he has consulted with the body recognized by the Commissioner of Education as the accrediting body for schools of medicine respecting approval of the application.

[(3) No institution or facility may receive more than one grant under this subsection. For payment under grants under this subsection, there is authorized to be appropriated $1,500,000 for the fiscal year ending September 30, 1977, and $1,500,000 for the fiscal year ending September 30, 1978.

[(4) Upon graduation of the second class from each school of medicine for which a grant was made under this subsection, the Secretary shall report to the Congress on the ability of the school of medicine to improve access to health care for residents of the geographical regions in which the clinical training programs of the school as located.]

* * * * * * *

FINANCIAL DISTRESS GRANTS

SEC. 789A. (a) The Secretary may make grants to schools of medicine, osteopathy, dentistry, public health, veterinary medicine, optometry, pharmacy, and podiatry which are in serious financial distress for the purposes of assisting in—

(1) meeting the costs of operation of any such school,

(2) meeting accreditation requirements if they have a special need to be assisted in meeting such requirements,

(3) carrying out appropriate operational, managerial, and financial reforms on the basis of information obtained in a comprehensive cost analysis study or on the basis of other relevant information,

(4) meeting the costs of maintaining the quality of their educational programs, and

(5) meeting the costs of strengthening their academic resources and capabilities.

A grant under this subsection shall be made for such period as the Secretary may specify.

(b) (1) No grant may be made under subsection (a) unless an application therefor is submitted to and approved by the Secretary. Such an application shall be in such form, submitted in such manner, and contain such information as the Secretary may prescribe.

(2) Any grant under subsection (a) may be made upon such terms and conditions as the Secretary determines to be reasonable and necessary, including requirements that the school agree—

(A) to disclose any financial information or data deemed by the Secretary to be necessary to determine the sources or causes of the school's financial distress,

(B) to conduct a comprehensive cost analysis study, and

(C) to carry out appropriate operational, managerial, and financial reforms as the Secretary may require, except that the Secretary shall not rquire changes in the educational component of the school's program.

(3) A recipient of a grant under subsection (a) must provide assurances satisfactory to the Secretary that the recipient will expend in carrying out its function as a school of medicine, osteopathy, dentistry, public health, veterinary medicine, optometry, pharmacy, or podiatry, as the case may be, during each fiscal year for which such grant is awarded an amount of funds (other than funds for construction, as determined by the Secretary) from non-Federal sources which is at least as great as the average amount of funds expended (excluding expenditures of a nonrecurring nature) by the recipient to carry out such functions in the two years preceding the year in which the grant is awarded.

(c) The Secretary may provide to any school eligible for a grant under subsection (a) technical assistance to enable the school to conduct a comprehensive cost analysis study of its operations, to identify operational inefficiencies, and to develop or carry out appropriate operational, managerial, and financial reforms.

(d) There are authorized to be appropriated for grants under subsection (a), $20,000,000 for the fiscal year ending September 30, 1981,

$20,000,000 for the fiscal year ending September 30, 1982, and $20,000,000, for the fiscal year ending September 30, 1983. Funds appropriated under this subsection shall remain available until expended.

Part G—Programs for Personnel in Health Administration and in Allied Health

Subpart I—Public Health Personnel

INSTITUTIONAL SUPPORT

Sec. 791. (a) Grants.—The Secretary shall make annual grants in accordance with this section to public and other nonprofit schools of public health.

(b) Grant Computation.—The amount of the annual grant under under subsection (a) to be made in a fiscal year to a school with an approved application for such fiscal year shall be an amount which bears the same ratio to the total amount appropriated for such fiscal year under subsection (d) as the sum of—

(1) the total number of full-time students enrolled in such school in the school year beginning in such fiscal year, and

(2) the number of full-time equivalents of part-time students in such school for such school year,

bears to the sum of the total number of full-time students enrolled in such school year and the number of such full-time equivalents for such schol year in all schools of public health with approved applications for such fiscal year.

(c) Enrollment Determinations.—For purposes of this section:

(1) Section 770(c) shall apply to regulations of the Secretary under this section relating to the determination of the number of full-time students enrolled in a school eligible for a grant under subsection (a).

(2) The number of full-time equivalents of part-time students in a school of public health for any school year is a number equal to—

(A) the total number of credit hours of instruction in such year for which part-time students in such school, who are pursuing a course of study leading to a graduate degree in public health or an equivalent degree, have enrolled, divided by

(B) the greater of (i) the number of credit hours of instruction which a full-time student in such school was required to take in such year, or (ii) 9,

rounded to the next highest whole number.

(3) The term "full-time students" (whether such term is used by itself or in connection with a particular year-class) means students pursuing a full-time course of study leading to a graduate degree in public health or an equivalent degree.

(d) Authorizations of Appropriations.—For the purpose of making grants under subsection (a) there are authorized to be appropriated $7,000,000 for the fiscal year ending September 30, 1981, $8,000,000 for the fiscal year ending September 30, 1982, and $9,000,000 for the fiscal year ending September 30, 1983.

(e) GRANT REQUIREMENTS.—The Secretary shall not make a grant under subsection (a) to any school in a fiscal year beginning after September 30, 1980, unless—

(1) the application for the grant contains, or is supported by, assurances satisfactory to the Secretary that the applicant will expend in carrying out its functions as a school of public health during the fiscal year for which such grant is sought, an amount of funds (other than funds for construction as determined by the Secretary) from non-Federal sources which is at least as great as the amount of funds expended by such applicant for such purpose (excluding expenditures of a nonrecurring nature) in the fiscal year preceding the fiscal year for which such grant is sought; and

(2) the school maintains an enrollment of full-time first-year students, for the school year beginning in the fiscal year for which a grant under subsection (a) is sought, which exceeds the number of full-time students enrolled in such school in the school year beginning in the fiscal year ending September 30, 1978—

(A) by 5 percent of such number if such number was not more than 100, or

(B) by 2.5 percent of such number, or 5 students, whichever is greater, if such number was more than 100.

The Secretary may waive (in whole or in part) application of the requirements of paragraph (2) to a school if the Secretary determines, after receiving the written recommendation of the appropriate accreditation body or bodies (approved for such purposes by the Secretary of Education) that compliance by such school with such requirement will prevent it from maintaining its acceditation.

(f) APPLICATIONS.—

(1) No grant may be made under subsection (a) unless an application therefor is submitted to and approved by the Secretary. The Secretary may from time to time set dates (not earlier than in the fiscal year preceding the year for which a grant is sought) by which such applications must be filed.

(2) To be eligible for a grant under subsection (a) the applicant must be accredited as determined in accordance with section 772(b).

(3) The Secretary shall not approve or disapprove any application for a grant under subsection (a) except after consultation with the National Advisory Council on Health Professions Education (established by section 702).

(4) A grant under subsection (a) may be made only if the application therefor—

(A) is approved by the Secretary upon his determination that the applicant (and its application) meet the eligibility conditions prescribed by subsection (e) and paragraph (2) of this subsection;

(B) contains such additional information as the Secretary may require to make the determinations required of him under subsection (a); and

(C) provides for such fiscal control and accounting procedures and reports, including the use of such standard proce-

dures for the recording and reporting of financial information as the Secretary may prescribe, and access to the records of the applicant, as the Secretary may require to enable him to determine the costs to the applicant of its program for the education or training of students.

PUBLIC HEALTH TRAINEESHIPS

SEC. [748] *792.* (a) The Secretary may make grants to—

(1) accredited schools of public health, and

(2) other public or nonprofit institutions which provide graduate or specialized training in public health and which are not eligible to receive a grant under section [749] *794B*,

to provide traineeships.

(b) (1) No grant for traineeships may be made under subsection (a) unless an application therefor has been submitted to, and approved by, the Secretary. Such application shall be in such form, be submitted in such manner, and contain such information, as the Secretary by regulation may prescribe. Traineeships under such a grant shall be awarded in accordance with such regulations as the Secretary shall prescribe. The amount of any such grant shall be determined by the Secretary.

(2) Traineeships awarded under grants made under subsection (a) shall provide for tuition and fees and such stipends and allowances (including travel and subsistence expenses and dependency allowances) for the trainees as the Secretary may deem necessary.

(3) In awarding traineeships under this section, each applicant shall assure to the satisfaction of the Secretary that at least the percent specified in paragraph (4) of the funds received under this section shall go to individuals who—

(A) (i) have previously received a [postbaccalaureate] *baccalaureate* degree, or

(ii) have three years of work experience in health services; and

(B) are pursuing a coure of study in—

(i) biostatistics or epidemiology,

(ii) health administration, health planning, or health policy analysis and planning,

(iii) environmental or occupational health,

(iv) dietetics or nutrition, or

(v) preventive medicine or dentistry, or

(vi) maternal and child health.

(4) The percent referred to in paragraph (3) is—

(A) 45 percent for grants made for the fiscal year ending September 30, 1978,

(B) 55 percent for grants made for the fiscal year ending September 30, 1979, and

(C) 65 percent for grants made for fiscal year ending September 30, 1980, and in succeeding fiscal years.

(c) For payments under grants under subsection (a), there are authorized to be appropriated $7,500,000 for the fiscal year ending September 30, 1978; $9,000,000 for the fiscal year ending September 30, 1979; [and] $10,000,000 for the fiscal year ending September 30, 1980;

$8,000,000 for the fiscal year ending September 30, 1981, $9,000,000 for the fiscal year ending September 30, 1982, and $10,000,000 for the fiscal year ending September 30, 1983.

SPECIAL PROJECTS FOR ACCREDITED SCHOOLS OF PUBLIC HEALTH [AND GRADUATE PROGRAMS IN HEALTH ADMINISTRATION]

SEC. [792.] *793.* (a) The Secretary may make grants to assist accredited schools of public health in meeting the costs of special projects to develop new programs or to expand existing programs in—

(1) biostatistics or epidemiology,

(2) health administration, health planning, or health policy analysis and planning,

(3) environmental or occupational health,

(4) dietetics and nutrition, or

(5) maternal and child health.

[(b) The Secretary may make grants to assist educational institutions in meeting the costs of special projects in—

[(1) biostatistics or epidemiology,

[(2) health administration, health planing, or health policy analysis and planning,

[(3) environmental or occupational health, or

[(4) dietetics and nutrition.]

[(c)] (*b*) There are authorized for the purpose of making payments under grants under this section $5,000,000 for the fiscal year ending September 30, 1978; $5,500,000 for the fiscal year ending September 30, 1979; [and] $6,000,000 for the fiscal year ending September 30, 1980; *$5,000,000 for the fiscal year ending September 30, 1981; $5,500,000 for the fiscal year ending September 30, 1982; and $6,000,000 for the fiscal year ending September 30, 1983.*

MIDCAREER TRAINING AND EDUCATION

SEC. 794. (a) The Secretary may make grants to and enter into contracts with public and nonprofit private entities for the establishment, operation, and administration of centers to provide intensive, short-term, advanced training, to individuals with demonstrated expertise in health policy and management, in—

(1) health systems management,

(2) health policy, planning, and regulation,

(3) environmental policy and management,

(4) financial management and strategy in health care,

(5) the management of collaboration between health care entities,

(6) the management of small health care entities in inner cities and rural areas, and

(7) other matters which will increase the capabilities of such individuals and broaden their perspectives in carrying out their functions.

(b)(1) The amount of any grant or contract under subsection (a) shall be determined by the Secretary. No grant may be made or contract entered into unless an application therefor is submitted to and

approved by the Secretary. Such an application shall be in such form, submitted in such manner, and contain such information, as the Secretary shall by regulation prescribe.

(2) The Secretary shall, to the extent feasible, make grants and enter into contracts under subsection (a) for centers in such a manner that there is an appropriate geographic distribution of the centers.

(c) For the purpose of making grants and contracts under subsection (a) there are authorized to be apropriated $500,000 for the fiscal year ending September 30, 1981, $2,500,000 for the fiscal year ending September 30, 1982, and $3,000,000 for the fiscal year ending September 30, 1983.

GRANTS FOR GRADUATE PROGRAMS IN HEALTH ADMINITSRATION

SEC. [791] *794A.* (a) From funds appropriated under subsection (d), the Secretary shall make annual grants to public or nonprofit private educational entities (including schools or social work and excluding accredited schools of public health) to support the graduate educational programs of such entities in health administration hospital administration, and health planning.

(b) The amount of the grant for any fiscal year under subsection (a) to an educational entity with an application approved under subsection (c) shall be equal to the amount appropriated under subsection (d) for such fiscal year divided by the number of educational entities which have applications for grants for such fiscal year approved under subsection (c).

(c) (1) No grant may be made under subsection (a) unless an application therefor has been submitted to the Secretary before such time as he shall by regulation prescribe and has been approved by the Secretary. Such application shall be in such form, and submitted in such manner, as the Secretary shall by regulation, prescribe.

(2) The Secretary may not approve an application submitted under paragraph (1) unless—

(A) such application—

(i) contains assurances satisfactory to the Secretary that in the school year (as defined in regulations of the Secretary) beginning in the fiscal year for which the applicant receives a grant under subsection (a) that—

(I) at least 25 individuals will complete the graduate educational programs of the entity for which such application is submitted; and

(II) such entity shall expend or obligate at least [$100,000] *$150,000* in funds from non-Federal sources to conduct such programs;

(ii) contains assurances satisfactory to the Secretary that such entity shall maintain a first-year enrollment of full-time students in the programs, for the school year beginning in the fiscal year ending September 30, [1978] *1981*, and for each school year thereafter beginning in a fiscal year for which a grant under this section is applied for, which exceeds the number of full-time, first-year students enrolled in such programs in the school year beginning in the fiscal year ending September 30, [1976] *1980*—

(I) by 5 percent of such number if such number was not more than 100, or

(II) by 2.5 percent of such number, or 5 students, whichever is greater, if such number was more than 100; [and]

(iii) contains assurances satisfactory to the Secretary that the program for which such application was submitted shall provide a concentration or special emphasis on one or more of the following:

(I) health planning,

(II) health policy,

(III) ambulatory care services,

(IV) long-term care,

(V) home health care,

(VI) multi-unit care systems,

(VII) comprehensive prepaid service systems,

(VIII) mental health administration, and

(IX) any other health care delivery system determined by the Secretary to require special emphasis; and

[(iii)](*iv*) contains such other information as the Secretary may be regulation prescribe; and

(B) the program for which such application was submitted has been accredited for the training of individuals for health administration hospital administration or health planning by a recognized body or bodies approved for such purpose by the [Commissioner] *Secretary* of education and meets such other quality standards as the Secretary shall be regulation prescribe.

(3) The Secretary may waive (in whole or in part) the requirements of clause (ii) of paragraph (2)(A) with respect to any school upon written notification by the appropriate accreditation body or bodies that compliance with the assurances required by such paragraph will prevent such school from meeting the accreditation standards of such body or bodies.

(4) The Secretary may not approve or disapprove an application submitted under paragraph (1) except after consultation with the National Advisory Council on Health Professions Education.

(d) There are authorized to be appropriated for payments under grants under this section $3,250,000 for the fiscal year ending September 30, 1978, $3,500,000 for the fiscal year ending September 30, 1979 [and] $3,750,000 for the fiscal year ending September 30, 1980, *$4,000,000 for the fiscal year ending September 30, 1981, $4,500,000 for the fiscal year ending September 30, 1982, and $5,000,000 for the fiscal year ending September 30, 1983.*

TRAINEESHIPS FOR STUDENTS IN GRADUATE PROGRAMS

SEC. [749.] *794B.* (a) The Secretary may make grants to public or nonprofit private educational entities, including graduate schools of social work but excluding accredited schools of public health, which offer a program in health administration, hospital administration, or health policy analysis and planning, which program is accredited by a body or bodies approved for such purpose by the Commissioner of Education and which meets such other quality standards

as the Secretary by regulation may prescribe, for traineeships to train students enrolled in such a program.

(b) (1) No grant for traineeships may be made under subsection (a) unless an application therefor has been submitted to, and approved by, the Secretary. Such application shall be in such form, be submitted in such manner, and contain such information, as the Secretary by regulation may prescribe. Traineeships under such a grant shall be awarded in accordance with such regulations as the Secretary shall prescribe. The amount of any such grant shall be determined by the Secretary.

(2) Traineeships awarded under grants made under subsection (a) shall provide for tuition and fees and such stipends and allowances (including travel and subsistence expenses and dependency allowances) for the trainees as the Secretary may deem necessary.

(3) In awarding traineeships under this section, each applicant shall assure to the satisfaction of the Secretary that at least 80 percent of the funds received under this section shall go to individuals who (A) have previously received a [postbaccalaureate] *baccalaureate* degree, or (B) have three years of work experience in health services.

(c) For payments under grants under subsection (a), there are authorized to be appropriated $2,500,000 for the fiscal year ending September 30, 1978; $2,500,000 for the fiscal year ending September 30, 1979; [and] $2,500,000 for the fiscal year ending September 30, 1980 *; $2,500,000 for the fiscal year ending September 30, 1981; $3,000,000 for the fiscal year ending September 30, 1982; and $3,500,000 for the fiscal year ending September 30, 1983.*

GRANTS TO DEPARTMENTS OF PREVENTIVE OR COMMUNITY MEDICINE OR DENTISTRY

SEC. 794C. (a) The Secretary may make grants to schools of medicine, dentistry, and osteopathy for the costs of projects—

(1) to establish, maintain, and improve academic administrative units in preventive or community medicine or dentistry;

(2) to improve predoctoral and postdoctoral instruction in preventive, community, or occupational medicine or dentistry;

(3) to plan, develop, and operate joint programs between academic administrative units in preventive or community medicine or dentistry and such units in other clinical specialties, which programs integrate the teaching of clinical preventive, community, or occupational medicine or dentistry within clinical programs for other medical or dental disciplines; and

(4) to plan, develop, and operate special programs to train teachers and researchers in the fields of preventive, community, or occupational medicine or dentistry.

(b) (1) The amount of any grant under subsection (a) shall be determined by the Secretary. No grant may be made under subsection (a) unless an application therefor is submitted to and approved by the Secretary. Such an application shall be in such form, submitted in such manner, and contain such information, as the Secretary shall by regulation prescribe.

(2) To be eligible for a grant under subsection (a), an applicant school must have, or demonstrate an intention to establish, an academic

administrative unit in preventive or community medicine or dentistry or an academic or administrative unit which has the primary responsibility, within that medical, dental, or osteopathic school, for teaching the principles of preventive or community medicine or dentistry.

(c) For the purpose of making grants under subsection (a), there are authorized to be appropriated $2,000,000 for the fiscal year ending September 30, 1981; $3,000,000 for the fiscal year ending September 30, 1982; and $4,000,000 for the fiscal year ending September 30, 1983.

TRAINING IN PREVENTIVE MEDICINE

Sec. 794D. (a) The Secreary may make grants to schools of medicine and schools of public health to meet the costs of projects—

(1) to plan and develop new residency training programs and to develop and expand accredited residency training programs in preventive medicine; and

(2) to provide financial assistance to residency trainees enrolled in such programs.

(b)(1) The amount of any grant under subsection (a) shall be determined by the Secretary. No grant may be made under subsection (a) unless an application therefor is submitted to and approved by the Secretary. Such an application shall be in such form, submitted in such manner, and contain such information, as the Secretary shall by regulation prescribe.

(2) To be eligible for a grant under subsection (a), the applicant must demonstrate to the Secretary that it has or will have available full-time faculty members with training and experience in the fields of preventive medicine and support from other faculty members trained in public health and other relevant specialties and disciplines.

(c) For the purpose of making grants under subsection (a), there are authorized to be appropriated $6,000,000 for fiscal year ending September 30, 1981; $7,000,000 for the fiscal year ending September 30, 1982: and $8,000,000 for the fiscal year ending September 30, 1983.

SPECIAL CURRICULA DEVELOPMENT PROJECTS FOR GRADUATE PROGRAMS IN HEALTH ADMINISTRATION

Sec. 794E. (a) The Secretary may make grants to assist education institutions with accredited programs in health administration to meet the costs of developing curricula designed to improve training in health care management. Such curricula may include—

(1) finance (particularly as applied to health care);

(2) marketing (particularly as applied to health care);

(3) economics (including macro-economics and micro-economics, and with special emphasis on health economics);

(4) epidemiology and health planning;

(5) health policy, law, and regulation;

(6) quality assurance and assessment;

(7) information systems;

(8) health services organization and management for students in health disciplines other than health administration; and

(9) management of ambulatory care services.

(b) For purposes of subsection (a), the term "accredited program in health administration" means a graduate program which is accredited for the purpose of training individuals in health administration by a body or bodies approved for such purpose by the Secretary of Education and which meets such other standards as the Secretary of Education may by regulation prescribe.

(c) For the purpose of making grants under subsection (a), there are authorized to be appropriated $3,000,000 for the fiscal year ending September 30, 1981, $4,000,000 for the fiscal year ending Sepetmber 30, 1982, and $5,000,000 for the fiscal year ending September 30, 1983.

FACULTY DEVELOPMENT PROGRAMS

SEC. 794F. (a) The Secretary may make grants to assist accredited schools of public health and other education institutions with accredited programs in health administration to meet the costs of establishing and operating faculty development programs. Such faculty development program shall—

(1) train individuals in management or other disciplines that are, in the judgment of the Secretary, underrepresented in programs of health administration and necessary to improve training in health care management; and

(2) train individuals experienced in such disciplines with respect to health care issues relating to the teaching of health administration.

(b) No grant may be made under subsection (a) unless an application therefor is submitted to and approved by the Secretary. Such an application shall be in such form, be submitted in such manner, and contain such information as the Secretary shall prescribe. The Secretary may not approve an appliction for a grant under subsection (a) unless such application contains assurances satisfactory to the Secretary that at least three individuals shall complete the program in each year for which an application is made.

(c) Grant funds awarded under subsection (a) shall be used to provide 12 month fellowships to individuals who—

(1) have received a doctoral degree or equivalent professional recognition in a discipline determined by the Secretary to be underrepresented in programs of health administration and necessary to improve training in health care management; and

(2) agree to serve as a faculty member for a period of not less than two years in an accredited school of public health or other educational program with accredited programs in health administration.

(d) For the purpose of making grants under subsection (a), there are authorized to be appropriated $1,000,000 for the fiscal year ending September 30, 1981, $1,000,000 for the fiscal year ending September 30, 1982, and $1,000,000 for the fiscal year ending September 30, 1983.

STATISTICS AND ANNUAL REPORT

SEC. [793.] *794G.* (a) The Secretary shall, in coordination with the National Center for Health Statistics (established under section 306), continuously develop, publish, and disseminate on a nationwide

basis statistics and other information respecting public and community health personnel, including—

(1) detailed descriptions of the various types of activities in which public and community health personnel are engaged,

(2) the current and anticipated needs for the various types of public and community health personnel, and

(3) the number, employment, geographic locations, salaries, and surpluses and shortages of public and community health personnel, the educational and licensure requirements for the various types of such personnel, and the cost of training such personnel.

(b) (1) The Secretary and each program entity shall in securing and maintaining any record of individually identifiable personal data (hereinafter in this subsection referred to as "personal data") for purposes of this section—

(A) inform any individual who is asked to supply personal data whether he is legally required, or may refuse, to supply such data and inform him of any specific consequences, known to the Secretary or program entity as the case may be, of providing or not providing such data;

(B) upon request, inform any individual if he is the subject of personal data secured or maintained by the Secretary or program entity, as the case may be, and make the data available to him in a form comprehensible to him;

(C) assure that no use is made of personal data which is not within the purposes of this section unless an informed consent has been obtained from the individual who is the subject of such data; and

(D) upon request, inform any individual of the use being made of personal data respecting such individual and of the identity of the individuals and entities which will use the data and their relationship to the activities conducted under this section.

(2) Any entity which maintains a record of personal data and which receives a request from the Secretary or a program entity to use such data for purposes of this section shall not transfer any such data to the Secretary or to a program entity unless the individual whose personal data is to be so transferred gives an informed consent for such transfer.

(3) (A) Notwithstanding any other provision of law, personal data collected by the Secretary or any program entity for purposes of this section may not be made available or disclosed by the Secretary or any program entity to any person other than the individual who is the subject of such data unless (i) such person requires such data for purposes of this section, or (ii) in response to a demand for such data made by means of compulsory legal process. Any individual who is the subject of personal data made available or disclosed under clause (ii) shall be notified of the demand for such data.

(B) Subject to all applicable laws regarding confidentiality, only the data collected by the Secretary under this section which is not personal data shall be made available to bona fide researchers and policy analysts (including the Congress) for the purposes of assisting in the conduct of studies respecting health professions personnel.

(4) For purposes of this subsection, the term "program entity" means any public or private entity which collects, compiles, or analyzes health professions data under an arrangement with the Secretary for purposes of this section.

(c) The Secretary shall submit biennially to the Committee on Interstate and Foreign Commerce of the House of Representatives and to the Committee on Labor and Public Welfare of the Senate a report on—

(1) the statistics and other information developed pursuant to subsection (a), and

(2) the activities conducted under this subpart, including an evaluation of such activities.

Such report shall contain such recommendations for legislation as the Secretary determines are needed to improve the programs authorized under this subpart. The Office of Management and Budget may review such report before its submission to such Committees, but the Office may not revise the report or delay its submission beyond the date prescribed for its submission and may submit to such Committees its comments respecting such report. The first report under this subsection shall be submitted not later than October 1, 1979.

(d) For purposes of this section, the term "public and community health personnel" means individuals who are engaged in—

(1) the planning, development, monitoring, or management of health care or health care institutions, organizations, or systems,

(2) research on health care development and the collection and analysis of health statistics, data on the health of population groups, and any other health data,

(3) the development and improvement of individual and community knowledge of health (including environmental health and preventive medicine) and the health care system, or

(4) the planning and development of a healthful environment and control of environmental health hazards.

Subpart II—Allied Health Personnel

DEFINITIONS

SEC. 795. For purposes of this subpart:

(1) The term "allied health personnel" means individuals with training and responsibilities for (A) supporting, complementing, or supplementing the professional functions of physicians, dentists, and other health professionals in the delivery of health care to patients, or (B) assisting environmental engineers and other personnel in environmenal health control and preventive medicine activities.

(2) The term "training center for allied health professions" means a junior college, college, or university—

(A) which provides, or can provide, programs of education leading to a baccalaureate or associate degree (or to the equivalent of either) or to a higher degree in [medical technology, optometric technology, dental hygiene, or in

any of such other of] *such of* the allied health professions curricula as are specified by regulation, or which, if in a junior college, provides a program (i) leading to an associate or an equivalent degree, (ii) of education in [optometric technology, dental hygiene, or such other curricula] *such curricula* as are specified by regulation, and (iii) acceptable for full credit toward a baccalaureate or equivalent degree in the allied health professions or designed to prepare the student to work as a technician in a health occupation specified by regulations of the Secretary.

(B) which provides training for not less than a total of twenty persons in such curricula,

(C) which, if in a college or university which does not include a teaching hospital or in a junior college, is affiliated (to the extent and in the manner determined in accordance with regulations) with such a hospital, and

(D) which is (or is in a college or university which is) accredited by a recognized body or bodies approved for such purpose by the Commissioner of Education, or which is in a junior college which is accredited by the regional accrediting agency for the region in which it is located or there is satisfactory assurance afforded by such accrediting agency to the Secretary that reasonable progress is being made toward accreditation by such junior college,

except that an applicant for a grant under this subpart which does not at the time of application meet the requirement of subparagraph (B) shall be deemed to meet such requirement if the Secretary finds there is reasonable assurance that the unit will meet the requirement of subparagraph (B) prior to the beginning of the academic year following the normal graduation date of the first entering class in such unit.

(3) The term "nonprofit" as applied to any training center for allied health professions means such a training center which is an entity, or is owned and operated by an entity, no part of the net earnings of which inures or may lawfully inure, to the benefit of any private shareholder or individual; and as applied to any entity means an entity no part of the net earnings of which inures or may lawfully inure to the benefit of any private shareholder or individual.

PROJECT GRANTS AND CONTRACTS

SEC. 796. (a) * * *

* * * * * * *

(d) (1) For the purpose of making payments under grants and contracts under subsection (a), there are authorized to be appropriated $22,000,000 for the fiscal year ending September 30, 1978; $24,000,000 for the fiscal year ending September 30, 1979; [and] $26,000,000 for the fiscal year ending September 30, 1980; *$9,000,000 for the fiscal year ending September 30, 1981; $9,500,000 for the fiscal year ending September 30, 1982; and $10,000,000 for the fiscal year ending September 30, 1983.*

* * * * * * *

TRAINEESHIPS FOR ADVANCED TRAINING OF ALLIED HEALTH PERSONNEL

* * * * * * *

SEC. 797. (a) * * *

(c) for the purposes of making payments under grants under subsection (a), there are authorized to be appropriated $4,500,000 for the fiscal year ending September 30, 1978; $5,000,000 for the fiscal year ending September 30, 1979; [and] $5,500,000 for the fiscal year ending September 30, 1980; *$1,000,000 for the fiscal year ending September 30, 1981; $1,400,000 for the fiscal year ending September 30, 1982; and $1,500,000 for the fiscal year ending September 30, 1983.*

* * * * * * *

EDUCATIONAL ASSISTANCE TO DISADVANTAGED INDIVIDUALS IN ALLIED HEALTH TRAINING

SEC. 798. (a) (1) * * *

* * * * * * *

(c) For payments under grants and contracts under subsection (a) there are authorized to be appropriated $1,000,000 for fiscal year ending September 30, 1978, $1,000,000 for fiscal year ending September 30, 1979, [and] $1,000,000 for fiscal year ending September 30, 1980, *$1,000,000 for the fiscal year ending September 30, 1981, $1,000,000 for the fiscal year ending September 30, 1982, and $1,000,000 for the fiscal year ending September 30, 1983.*

TITLE VIII—NURSE TRAINING

PART A—ASSISTANCE FOR EXPANSION AND IMPROVEMENT OF NURSE TRAINING

Subpart I—Construction Assistance

AUTHORIZATION OF APPROPRIATIONS FOR CONSTRUCTION GRANTS

SEC. 801. There are authorized to be appropriated for grants to assist in the construction of new facilities for collegiate, associate degree, or diploma schools of nursing *in health manpower shortage areas designated under section 332*, and for grants to assist in the replacement or rehabilitation of existing facilities for such schools, $35,000,000 for the fiscal year ending June 30, 1972, $40,000,000 for the fiscal year ending June 30, 1973, $45,000,000 each for the fiscal years ending June 30, 1974, and June 30, 1975, $20,000,000 for fiscal year 1976, $20,000,000 for fiscal year 1977, $20,000,000 for fiscal year 1978, [and] $2,000,000 for the fiscal year ending September 30, 1980, *$1,000,000 for the fiscal year ending September 30, 1981, $1,000,000 for the fiscal year ending September 30, 1982, and $1,000,000 for the fiscal year ending September 30, 1983.*

APPROVAL OF APPLICATIONS FOR CONSTRUCTION GRANTS

SEC. 802. (a) The Secretary may from time to time set dates (not earlier than in the fiscal year preceding the year for which a grant is

sought) by which applications for grants under this subpart for any fiscal year must be filed.

(b) A grant for a construction project under this subpart may be made only if the application therefor is approved by the Secretary upon his determination that—

(1) the applicant is a public or nonprofit private school of nursing providing an accredited program of nursing education *in a health manpower shortage area designated under section 332*;

(2) the application contains or is supported by reasonable assurances that (A) for not less than twenty years (or in the case of interim facilities, within such shorter period as the Secretary shall by regulation prescribe) after completion of construction, the facility will be used for the purposes of the training for which it is to be constructed, and will not be used for sectarian instruction or as a place for religious worship, (B) sufficient funds will be available to meet the non-Federal share of the cost of constructing the facility, (C) sufficient funds will be available, when construction is completed, for effective use of the facility for the training for which it is being constructed, and (D) in the case of an application for a grant for construction to expand the training capacity of a school of nursing, the first-year enrollment at such school during the first full school year after the completion of the construction and for each of the nine years thereafter will exceed the highest first-year enrollment at such school for any of the five full school years preceding the year in which the application is made by at least 5 per centum of such highest first-year enrollment, or by five students, whichever is greater, and the requirements of this clause (D) shall be in addition to the requirements of section 810(c) of this Act, where applicable;

(3) (A) in the case of an application for a grant for construction of a new facility, such application is for aid in the construction of a new school of nursing, or construction which will expand the training capacity of an existing school of nursing, or (B) in the case of an application for a grant to assist in the replacement or rehabilitation of existing facilities, such application is for aid in construction which will replace or rehabilitate facilities of, or used by, an existing school of nursing, which facilities either are so obsolete as to require the school to curtail substantially either its enrollment or the quality of the training provided or are required to meet an increase in student enrollment;

(4) the plans and specifications are in accordance with regulations relating to minimum standards of construction and equipment; and

(5) the application contains or is supported by adequate assurances that all laborers and mechanics employed by contractors or subcontractors in the performance work on a project will be paid wages at rates not less than those prevailing on similar construction in the locality as determined by the Secretary of Labor in accordance with the Act of March 3, 1931 (40 U.S.C. 276a—276a–5, known as the Davis-Bacon Act) and the Secretary of Labor shall have with respect to such labor standards the authority and functions set forth in Reorganization Plan Numbered 14

of 1950 (15 F.R. 3176; 5 U.S.C. Appendix) and section 2 of the Act of June 13, 1934 (40 U.S.C. 276c).

Before approving or disapproving an application for a construction project under this subpart, the Secretary shall secure the advice of the National Advisory Council on Nurse Training established by section 851.

LOAN GUARANTEES AND INTEREST SUBSIDIES

SEC. 805. (a) In order to assist nonprofit private schools of nursing to carry out construction projects for training facilities, the Secretary may, during the period beginning July 1, 1971, and ending with the close of September 30, [1980,] *1983*, guarantee (in accordance with this section and subject to subsection (f)) to non-Federal lenders or the Federal Financing Bank making loans to such schools for such construction projects payment when due of the principal of and interest on any loan for construction of such facilities if the loan was made to a school which is eligible (as determined under regulations of the Secretary) for a grant under this subpart to assist a construction project for such facilities. The Secretary may make commitments, on behalf of the United States, to make such loan guarantees prior to the making of such loans. No such loan guarantee may, except under such special circumstances and under such conditions as are prescribed by regulations, apply to any amount which, when added to any grant for construction under this subpart or any other law of the United States, exceeds 90 per centum of the cost of construction of the projects.

* * * * * * *

Subpart II—Capitation Grants

[CAPITATION GRANTS] *INSTITUTIONAL SUPPORT*

SEC. 810. (a) GRANT COMPUTATION.—The Secretary shall make annual grants to schools of nursing for the support of the education programs of such schools. The amount of the annual grant to each such school with an approved application shall be computed for each fiscal year as follows:

[(1) Each collegiate school of nursing shall receive $400 for each undergraduate full-time student enrolled in each of the last two years of such school in such fiscal year.

[(2) Each associate degree school of nursing shall receive (A) the product of $275 and one-half of the number of full-time students enrolled in the first year of such school in such fiscal year, and (B) $275 for each full-time student enrolled in the last year of such school in such year.

[(3) Each diploma school of nursing shall receive $250 for each full-time student enrolled in such school in such fiscal year.]

(1)(A) For the fiscal year ending September 30, 1981, each collegiate school of nursing shall receive an amount equal to the product of——

(i) $200, and

(ii) the sum of (I) the number of full-time students enrolled in each of the last two years of such school in the fiscal year for which the grant is to be made, and (II) the

number of full-time equivalents of part-time students for such school for such fiscal year.

(B) For the fiscal year ending September 30, 1982, each collegiate school of nursing shall receive an amount equal to the product of $210 and the sum described in subparagraph (A)(ii).

(C) For the fiscal year ending September 30, 1983, each collegiate school of nursing shall receive an amount equal to the product of $220 and the sum described in subparagraph (A)(ii).

(2)(A) For the fiscal year ending September 30, 1981, each associate degree school of nursing and each diploma school of nursing shall receive an amount equal to the product of—

(i) $200, and

(ii) the sum of (I) the number of full-time students enrolled in such school in the fiscal year for which the grant is to be made, and (II) the number of full-time equivalents of part-time students for such school for such fiscal year.

(B) For the fiscal year ending September 30, 1982, each such school of nursing shall receive an amount equal to the product of $210 and the sum described in subparagraph (A)(ii).

(C) For the fiscal year ending September 30, 1983, each such school of nursing shall receive an amount equal to the product of $220 and the sum described in subparagraph (A)(ii).

(c)(1) REQUIREMENTS FOR GRANTS.—* * *

(2) The Secretary shall not make a grant under subsection (a) to any school of nursing in a fiscal year beginning after [June 30, 1975, unless one of the following requirements is met:

[(A) The application for such grant shall contain or be supported by reasonable assurances satisfactory to the Secretary that for the school year beginning in the fiscal year in which such grant is to be made and for each school year thereafter beginning in a fiscal year in which such a grant is made the first year enrollment of full-time students in such school will exceed the number of such students enrolled in the school year beginning during the fiscal year ending June 30, 1975—

[(i) by 10 per centum of such number if such number was not more than one hundred, or

[(ii) by 5 per centum of such number, or ten students, whichever is greater, if such number was more than one hundred.] *September 30, 1979, by 15 percent or 10 students, whichever is greater.*

[(B) The school has provided reasonable assurance satisfactory to the Secretary that it will carry out, in accordance with a plan submitted by the school to the Secretary and approved by him, at least two of the following programs in the school year beginning in the school year in which such grant is to be made and in each school year thereafter beginning in a school year in which such a grant is made:

[(i) In the case of collegiate schools of nursing, a program for the training of nurse practitioners (as defined in section 822).

[(ii) A program under which students enrolled in a school of nursing will receive a significant portion of their clinical training in community health centers, long-term care

facilities, and ambulatory care facilities geographically remote from the main site of the teaching facilities of the school.

[(iii) A program for the continuing education of nurses which meets needs identified by appropriate State, regional, or local health or educational entities (including health systems agencies).

[(iv) A program to identify, recruit, enroll, retain, and graduate individuals from disadvantaged backgrounds (as determined in accordance with criteria prescribed by the Secretary) under which program at least 10 per centum of each year's entering class (or ten students, whichever is greater) is comprised of such individuals.]

(B) In the case of a collegiate school of nursing, the school has provided reasonable assurances to the Secretary that it will carry out, in accordance with a plan submitted by the school to the Secretary and approved by the Secretary, in the school year beginning in the fiscal year in which such grant is to be made and in each school year thereafter beginning in a fiscal year in which such a grant is made, a program for the training of nurse practitioners (as defined in section 822).

(C) The application of the school for such grant contains or is supported by reasonable assurances satisfactory to the Secretary that it will carry out, in accordance with a plan submitted by the school to the Secretary and approved by the Secretary, in the school year beginning in the fiscal year in which such grant is to be made and in each school year thereafter beginning in a fiscal year in which such a grant is made, a program to identify, recruit, enroll, retain and graduate individuals from disadvantaged backgrounds (as determined in accordance with criteria prescribed by the Secretary) under which program at least 20 percent of each year's entering full-time students (or ten students, whichever is greater) is comprised of such individuals.

(D) In the case of a collegiate school of nursing, the application of the school for such grant contains or is supported by reasonable asurances satisfactory to the Secretary that in the school year beginning in the fiscal year in which such grant is to be made and in each school year thereafter beginning in a fiscal year in which such a grant is made at least 20 percent of each year's entering full-time students (or ten students, whichever is greater) shall be comprised of individuals who have a degree from an associate degree school of nursing or a diploma or equivalent indicia from a diploma school of nursing.

(E) In the case of an associate degree school of nursing or a diploma school of nursing, the application of the school for such grant contains or is supported by reasonable assurances satisfactory to the Secretary that in the school year beginning in the fiscal year in which such is to be made and in each school year thereafter beginning in a fiscal year in which such a grant is made at least 20 percent of each year's entering full-time students (or ten students, whichever is greater) shall be comprised of individuals who are licensed practical or vocational nurses.

(F) The application of the school for such grant contains or is supported by reasonable assurances satisfactory to the Secretary that in the school year beginning in the fiscal year in which such grant is to be made and in each school year thereafter beginning in a fiscal year in which such a grant is made the number of part-time students enrolled in the school in its program leading to the degree or diploma or equivalent indicia which it awards will be at least 20 percent of all the students enrolled in the school in such program.

(d) ENROLLMENT AND GRADUATION DETERMINATIONS.—

(1) For purposes of this part and part [D] *B;* regulations of the Secretary shall include provisions relating to determination of the number of students enrolled in a school, or in a particular year-class in a school, or the number of graduates, as the case may be, on the basis of estimates or on the basis of the number of students who were enrolled in a school, or in a particular year-class in school, or were graduates, in an earlier year, as the case may be, or on such basis as he deems appropriate for making such determination, and shall include methods of making such determination when a school or a year-class was not in existence in an earlier year at a school.

(2) For purposes of this part and part [D] *B*, the term "full-time students" (whether such term is used by itself or in connection with a particular year-class) means students pursuing a full-time course of study in an accredite program in a school of nursing.

(3) The number of full-time equivalents of part-time students for a school of nursing for any school year is a number equal to—

(A) the total number of credit hours of instruction in such year for which part-time students of such school, who are pursuing a course of study leading to a degree or diploma or equivalent indicia, have enrolled, divided by

(B) the number of credit hours of instruction which a full-time student of such school was required to take in such year, rounded to the next highest whole number, except that in the case of a collegiate school of nursing, only the credit hours of instruction in courses offered to students who are enrolled in the third or fourth year program of instruction of such school shall be considered in making the computation under paragraph (A).

(f) AUTHORIZATION OF APPROPRIATIONS.—

(1) There are authorized to be appropriated $78,000,000 for the fiscal year ending June 30, 1972, $82,000,000 for the fiscal year ending June 20, 1973, $88,000,000 each for the fiscal years ending June 30, 1974, and June 30, 1975, $50,000,000 for fiscal year 1976, $55,000,000 for fiscal year 1977, $55,000,000 for fiscal year 1978, [and] $24,000,000 for the fiscal year ending September 30, 1980, for grants under this section, *$25,000,000 for the fiscal year ending September 30, 1981, $27,500,000 for the fiscal year ending September 30, 1982, and $30,000,000 for the fiscal year ending September 30, 1983.*

* * * * * * *

Subpart IV—Special Projects

SPECIAL PROJECT GRANTS AND CONTRACTS

SEC. 820. (a) The Secretary may make grants to public and nonprofit private schools of nursing and other public or nonprofit private entities, and enter into contracts with any public or private entity, to meet the costs of special projects to—

[(1) assist in—

[(A) mergers between hospital training programs or between hospital training programs and academic institutions, or

[(B) other cooperative arrangements among hospitals and academic institutions,

leading to the establishment of nurse training programs;

[(2)(A) plan, develop, or establish new nurse training programs or programs of research in nursing education, or

[(B) significantly improve curricula of schools of nursing (including curriculums of pediatric nursing and geriatric nursing) or modify existing programs of nursing education;]

[(3)](*1*) increase nursing education opportunities for individuals from disadvantaged backgrounds, as determined in accordance with criteria prescribed by the Secretary, by

(A) identifying, recruiting, and selecting such individuals,

(B) facilitating the entry of such individuals into schools of nursing,

(C) providing counseling or other services designed to assist such individuals to complete successfully their nursing education,

(D) providing, for a period prior to the entry of such individuals into the regular course of education at a school of nursing, preliminary education designed to assist them to complete successfully such regular course of education,

(E) paying such stipends (including allowances for travel and dependents) as the Secretary may determine for such individuals for any period of nursing education, and

(F) publicizing, especially to licensed vocational or practical nurses, existing sources of financial aid available to persons enrolled in schools of nursing or who are undertaking training necessary to qualify them to enroll in such schools;

[(4)](*2*) provide continuing education for nurses;

[(5)](*3*) provide appropriate retraining opportunities for nurses who (after periods of professional inactivity) desire again actively to engage in the nursing profession;

[(6)](*4*) help to increase the supply or improve the distribution by geographic area or by specialty group of adequately trained nursing personnel (including nursing personnel who are bilingual) needed to meet the health needs of the Nation, including the need to increase the availability of personal health services and the need to promote preventive health care; *or*

[(7)](*5*) provide training and education to upgrade the skills of licensed vocational or practical nurses[, nursing assistants, and other paraprofessional nursing personnel; or].

[(8) assist in meeting the costs of developing short-term (not to exceed 6 months) in-service training programs for nurses aides and orderlies for nursing homes, which programs emphasize the special problems of geriatric patients and include training for monitoring the well-being and feeding and cleaning of the patients in nursing homes, emergency procedures, drug properties and interactions, and fire safety techniques.]

Contracts may be entered into under this subsection without regard to sections 3648 and 3709 of the Revised Statutes (31 U.S.C. 529; 41 U.S.C. 5).

* * * * * * *

(d) For payments under grants and contracts under this section there are authorized to be appropriated $15,000,000 for fiscal year 1976, $15,000,000 for fiscal year 1977, $15,000,000 for fiscal year 1978, [and] $17,000,000 for the fiscal year ending September 30, 1980, *$15,000,000 for the fiscal year ending September 30, 1981, $17,500,000 for the fiscal year ending September 30, 1982, and $20,000,000 for the fiscal year ending September 30, 1983.* [Not less than 10 per centum of the fnuds appropriated under this subsection for any fiscal year shall be used for payments under grants and contracts to meet the costs of the special projects described in subsection (a)(3).] *Of the funds appropriated under this subsection for any fiscal year beginning after September 30, 1980, not less than 20 percent of the funds shall be obligated for payments under grants and contracts for special projects described in subsection (a)(1) and not less than 20 percent of the funds shall be obligated for payments under grants and contracts for special projects described in subsection (a)(4).*

ADVANCED NURSE TRAINING PROGRAMS

SEC. 821. (a)(1) The Secretary may make grants to and enter into contracts with public and nonprofit private collegiate schools of nursing to meet the costs of projects to—

(A) plan, develop, and operate,

(B) significantly expand, or

(C) maintain existing

programs for the advanced training of professional nurses to [each] *teach* in the various fields of nurse training, to serve in administrative or supervisory capacities, or to serve in other professional nursing specialties (including service as nurse clinicians) determined by the Secretary to require advanced training.

(b) For payments under grants and contracts under this section there are authorized to be appropriated $15,000,000 for fiscal year 1976, $20,000,000 for fiscal year 1977, $25,000,000 for fiscal year 1978, [and] $13,500,000 for the fiscal year ending September 30, 1980, *$12,000,000 for the fiscal year ending September 30, 1981, $13,500,000 for the fiscal year ending September 30, 1982, and $15,000,000 for the fiscal year ending September 30, 1983.*

NURSE PRACTITIONER PROGRAMS

SEC. 822. (a)(1) * * *

* * * * * * *

(b) (1) The Secretary may make grants to and enter into contracts with schools of nursing, medicine, and public health, public or nonprofit private hospitals, and other nonprofit entities to establish and operate traineeship programs to train nurse practitioners [who are residents of a health manpower shortage area (designated under section 332)]. *In considering applications for a grant or contract under this subsection, the Secretary shall give special consideration to applications for traineeships to train individuals who are residents of health manpower shortage areas designated under section 332.*

* * * * * * *

(3) A traineeship funded under this subsection shall not be awarded unless the recipient enters into a commitment with the Secretary to practice as a nurse practitioner in a health manpower shortage area (designated under section 332) *for a period equal to one month for each month for which the recipient receives such a traineeship.*

(4) (A) If, for any reason, an individual who received a traineeship under paragraph (1) fails to complete a service obligation under paragraph (3), such individual shall be liable for the payment of an amount equal to the cost of tuition and other education expenses and other payments paid under the traineeship, plus interest at the maximum legal prevailing rate.

(B) When an individual who received a traineeship is academically dismissed or voluntarily terminates academic training, such individual shall be liable for repayment to the Government for an amount equal to the cost of tuition and other educational expenses paid to or for such individual from Federal funds plus any other payments which were received under the traineeship.

(C) Any amount which the United States is entitled to recover under subparagraph (A) or (B) shall, within the three-year period begining on the date the United States becomes entitled to recover such amount, be paid to the United States.

(D) The Secretary shall by regulation provide for the waiver or suspension of any obligation under subparagraph (A) or (B) applicable to any individual whenever compliance by such individual is impossible or would involve extreme hardship to such individual and if enforcement of such obligation with respect to any individual would be against equity and good conscience.

(e) For payments under grants and contracts under this section there are authorized to be appropriated $15,000,000 for fiscal year 1976, $20,000,000 for fiscal year 1977, $25,000,000 for fiscal year 1978, [and] $15,000,000 for fiscal year ending September 30, 1980, *$17,000,000 for the fiscal year ending September 30, 1981, $18,500,000 for fiscal year ending September 30, 1982, and $20,000,000 for the fiscal year ending September 30, 1983.*

Part B—Assistance to Nursing Students

Subpart I—Traineeships

Traineeships for advanced training of professional nurses

Sec. 830. (a) (1) The Secretary may make grants to public or private nonprofit institutions to cover the costs of traineeships for the training of professional nurses—

(A) to teach in the various fields of nurse training (including practical nurse training),

(B) to serve in administrative or supervisory capacities,

(C) to serve as nurse [practitioners] *midwives*, or

(D) to serve in other professional nursing specialties determined by the Secretary to require advanced training.

* * * * * * *

(b) There are authorized to be appropriated for the purposes of this section $15,000,000 for the fiscal year ending June 30, 1976, $20,000,000 for the fiscal year ending September 30, 1977, and $25,000,000 for the fiscal year ending September 30, 1978, [and] $15,000,000 for the fiscal year ending September 30, 1980, *$15,000,000 for the fiscal year ending September 30, 1981, $17,500,000 for the fiscal year ending September 30, 1982, and $20,000,000 for the fiscal year ending September 30, 1983. Not less than 50 percent of the funds appropriated under this subsection for any fiscal year shall be obligated for traineeships described in subsection (a)(1)(A), except that if the obligation of that amount of the funds appropriated under this subsection will prevent the Secretary from continuing a traineeship to an individual who received a traineeship under subsection (a) for the fiscal year ending September 30, 1980, the Secretary shall reduce the amount to be obligated for traineeship described in subsection (a)(1)(A) by such amount as may be necessary for the continuation of traineeships first awarded in such fiscal year.*

TRAINEESHIPS FOR TRAINING OF NURSE ANESTHETISTS

SEC. 831. (a)(1) * * *

(b) For the purpose of making grants under subsection (a), there are authorized to be appropriated $2,000,000 for the fiscal year ending September 30, 1980, *$2,000,000 for the fiscal year ending September 30, 1981, $3,000,000 for the fiscal year ending September 30, 1982, and $4,000,000 for the fiscal year ending September 30, 1983.*

Subpart II—Student Loans

LOAN AGREEMENTS

SEC. 835. (a) * * *

(b) Each agreement entered into under this section shall—

(1) provide for establishment of a student loan fund by the school;

(2) provide for deposit in the fund, except as provided in section 841, of (A) the Federal capital contributions paid from allotments under section 838 to the school by the Secretary, (B) an additional amount from other sources equal to not less than one-ninth of such Federal capital contributions, (C) collections of principal and interest on loans made from the fund, (D) collections pursuant to section 836(f), and (E) any other earnings of the fund;

(3) provide that the fund, except as provided in section 841, shall be used only for loans to students of the school in accordance with the agreement and for costs of collections of such loans and interest thereon;

(4) provide that loans may be made from such fund only to students pursuing a full-time or half-time course of study at the school leading to a baccalaureate or associate degree in nursing or an equivalent degree or a diploma in nursing, or to a graduate degree in nursing, and that while the agreement remains in effect no such student who has attended such school before October 1, [1980.] *1984*, shall receive a loan from a loan fund established under section 204 of the National Defense Education Act of 1958; and

(5) Contain such other provisions as are necessary to protect the financial interests of the United States.

LOAN PROVISIONS

SEC. 836. (a) The total of the loans for any academic year (or its equivalent, as determined under regulations of the Secreary) made by schools of nursing from loan funds established pursuant to agreements under this subpart may not exceed $2,500 in the cast of any student. The aggregate of the loans for all years from such funds may not exceed $10,000 in the case of any student. In the granting of such loans, a school shall give preference to licensed practical nurses and to persons who enter as first-year students after enactment of this title.

(b) Loans from any such student loan fund by any school shall be made on such terms and conditions as the school may determine; subject, however, to such conditions, limitations, and requirements as the Secretary may prescribe (by regulation or in the agreement with the school) with a view of preventing impairment of the capital of such fund to the maximum extent practicable in the light of the objective of enabling the student to complete his course of study; and except that—

(1) such a loan may be made only to a student who (A) *is in exceptionally needy circumstances or is from a low-income or disadvantaged family (as those terms are defined by regulations under subsection (j)) and* is in need of the amount of the loan to pursue a full-time or half-time course of study at the school leading to a baccalaureate or associate degree in nursing or an equivalent degree, or a diploma in nursing, or a graduate degree in nursing, and (B) is capable, in the opinion of the school, of maintaining good standing in such course of study;

* * * * * * *

(5) such a loan shall bear interest on the unpaid balance of the loan, computed only for periods during which the loan is repayable, at the rate of [3] *6* per centum per annum;

AUTHORIZATION OF APPROPRIATIONS FOR STUDENT LOAN FUNDS

SEC. 837. There are authorized to be appropriated for allotments under section 838 to schools of nursing for Federal capital contributions to their student loan funds established under section 835, $25,000,000 for fiscal year 1976, $30,000,000 for fiscal year 1977, $35,000,000 for fiscal year 1978, [and], $13,500,000 for the fiscal year ending September 30, 1980, *$15,000,000 for the fiscal year ending Septem-*

ber 30, 1981, $17,500,000 for the fiscal year ending September 30, 1982, and $20, 000,000 for the fiscal year ending September 33, 1983 .For the fiscal year ending September 30, [1981], *1984;* and for each of the next two succeeding fiscal years there are authorized to be appropriated such sums as may be necessary to enable students who have received a loan for any academic year ending before October 1, [1980], *1983;* to continue or complete their education.

DISTRIBUTION OF ASSETS FROM LOAN FUNDS

SEC. 839. (a) After September 30, [1983], *1986*, and not later than December 31, [1983], *1986*, there shall be a capital distribution of the balance of the loan fund established under an agreement pursuant to section 835(b) by each school as follows:

(1) The Secretary shall first be paid an amount which bears the same ratio to such balance in such fund at the close of September 30, [1983], *1986*, as the total amount of the Federal capital contributions to such fund by the Secretary pursuant to section 835(b)(2)(A) bears to the total amount in such fund derived from such Federal capital contributions and from funds deposited therein pursuant to section 835(b)(2)(B).

(2) The remainder of such balance shall be paid to the school.

(b) After December 31, [1983], *1986*, each school with which the Secretary has made an agreement under this subpart shall pay to the Secretary, not less often than quarterly, the same proportionate share of amounts received by the school after September 30, [1983] *1986*, in payment of principal or interest on loans made from the loan fund established pursuant to such agreement as was determined for the Secretary under subsection (a).

* * * * * * *

Subpart III—Scholarship Grants to Schools of Nursing

SCHOLARSHIP GRANTS

SEC. 845. (a) The Secretary shall make grants as provided in this section ot each public or other nonprofit school of nursing for scholarships to be awarded annually by such school to students thereof.

(b) The amount of the grant under subsection (a) for the fiscal year ending June 30, 1976, and for each of the next [four] *seven* fiscal years to each such school shall be equal to $3,000 multiplied by one-tenth of the number of full-time students of such school. For the fiscal year ending September 30, [1981], *1984*, and for each of the two succeeding fiscal years, the grant under subsection (a) shall be such amount as may be necessary to enable such school to continue making payments under scholarship awards to students who initially received such awards out of grants made to the school for fiscal years ending before October 1, [1980] *1983*.

(c)(1) Scholarships may be awarded by schools from grants under subsection (a)—

(A) only to individuals who have been accepted by them for enrollment, and individuals enrolled and in good standing, as full-time or half-time students, in the case of awards from such

grants for the fiscal year ending June 30, 1976, and for each of the next [four] *seven* fiscal years; and

(B) only to individuals enrolled and in good standing as full-time or half-time students who initially received scholarship awards out of such grants for a fiscal year ending prior to October 1, [1980] *1983*, in the case of awards from such grants for the fiscal year ending September 30, [1981] *1984*, and each of the two succeeding fiscal years.

(2) Scholarships from grants under subsection (a) for any school year shall be awarded only to students of exceptional financial need who need such financial assistance to pursue a course of study at the school for such year. Any such scholarship awarded for a school year shall cover such portion of the student's tuition, fees, books, equipment, and living expenses at the school making the award, but not to exceed $2,000 for any year in the case of any student, as such school may determine the student needs for such year on the basis of his requirements and financial resources.

(d) Grants under subsection (a) shall be made in accordance with regulations prescribed by the Secretary after consultation with the National Advisory Council on Nurse Training.

(e) Grants under subsection (a) may be paid in advance or by way of reimbursement, and at such intervals as the Secretary may find necessary; and with appropriate adjustments on account of overpayments or underpayments previously made.

* * * * * * *

Part C—General

National Advisory Council on Nurse Training; Review Committee

Sec. 851. (a) There is hereby established a National Advisory Council on Nurse Training, consisting of the Secretary or his delegate, who shall be Chairman, [, and the Commissioner of Education, both of whom shall be ex officio members] *and an ex officio member*, and nineteen members appointed by the Secretary without regard to the civil service laws. Three of the appointed members shall be selected from full-time students enrolled in schools of nursing, four of the appointed members shall be selected from the general public and twelve shall be selected from among leading authorities in the various fields of nursing, higher, and secondary education, and from representatives of hospitals and other institutions and organizations which provide nursing services. The student-members of the Council shall be appointed for terms of one year and shall be eligible for reappointment to the Council.

(b) The Council shall advise the Secretary or his delegate in the preparation of general regulations and with respect to policy matters arising in the administration of this title, and in the review of applications for construction projects under subpart I of part A, of applications under section 805, and of applications under subpart III of part A.

* * * * * * *

ADDITIONAL VIEWS OF MESSRS. MAGUIRE AND PREYER

The amendment to study the adequacy of the environmental and occupational health workforce was prompted by a number of concerns. First, we feel that agencies with environmental and occupational responsibilities have relegated personnel concerns to a rather low level and that little if any effort is made to project manpower needs over the long term. Next, we are concerned that Congress has not focused sufficiently on these issues and that Congressional and Executive policy concerning personnel needs are often at loggerheads. The resolution of the many problems associated with providing adequate environmental and occupational health manpower may be critical to assuring that the laws Congress has passed do the job intended and protect the public health.

A recent report by the Harvard School of Public Health ("Continuing Education in Environmental Health," Dade Moeller, Harvard School of Public Health, October, 1979) discuss a number of workforce variables. The report states that in the drafting of legislation in the environmental health field, little attention is given to associated manpower needs and, that only when the backlog of educational needs reaches the crisis stage, will Congress pass ameliorative legislation. This situation is exacerbated by the role played by OMB which has not been responsive to the increasing need for additional health manpower.

The Moeller report also states that Congress gives little attention to long-range environmental manpower planning and that almost no attention is given to continuing education needs of the environmental health workforce. In fact, industry and State governmental efforts in the field of continuing education far outstrip Federal efforts. The Moeller report adds ". . . most Congressional leaders recognize that the implementation of environmental health legislation is hampered frequently by a shortage of qualified personnel. They also recognize that Federal and State regulatory agencies are losing ground to industry in terms of their ability to defend the scientific basis for their environmental standards and to keep abreast of continuing and increasing challenges in this field.' (Moeller, pp. 25, 26.)

We are concerned that in our rush to abate threats to our environment, we have overlooked the adequacy of the workforce that will perform the myriad tasks associated with pollution control and abatement and the protection of the public health. We expect that the Secretary of Health and Human Services (DHHS) will determine whether, as suggested in several reports, there are shortages of certain types of environmental health personnel, such as toxicologists and epidemiologists and if so, how best to remedy such shortages. A study entitled "Human Health and Environment—Some Research Needs" (A Report of the Second Task Force for Research Planning

in Environmental Health Services, HEW 1976) states concerning the problem of projecting the need for qualified toxicologists:

> The effects of new legislation and other factors on the demand for practitioners can sometimes be projected, based on reasonable assumptions; for example, knowing how many health physicists are needed for a given nuclear power plant, one can project the number needed for any number of nuclear plants being planned. This cannot be done for research manpower. We know that implementation of the Toxic Substances Control Act will create a substantial demand for research toxicologists, but we can only guess how many P. 472.

The report states also that the apparent shortfall in the number of toxicologists is caused in part by the fact that Federal research training dollars to universities has not kept pace with Federal money for environmental health research which increased substantially from 1966 to 1976. According to the report:

> The output of research scientists from training institutions has reflected the vagaries of Federal funding in the several areas of environmental health, though it is also clear that market forces sustain a limited output in the absence of Federal support. Lack of training support was identified as the major limitation on training output by 52 percent of toxicology program directors in our survey. P. 472.

The report also comments that the demand for environmental health scientists is not being matched by the supply and that toxicology and epidemiology are critical shortage areas.

A recent study indicates that if environmental workforce deficiencies exist, they may be qualitative deficiencies, not quantitative ones, and that a possible remedy would be to retrain existing biomedical personnel in the discipline of toxicology. The Interagency Regulatory Liaison Group suggests that specialized, cross-training or retraining programs might remedy the shortage of toxicologists and that no new, massive training programs appear to be necessary. According to the IRLG:

> Toxicology is a deprived and uncertain discipline in this country. . . . (It) involves the application of different disciplines, and consequently the "discipline" of toxicology is murky. Well trained people are hotly competed for, and facilities are limited . . . Passage of new Federal statutes such as the Resource Recovery and Conservation Act, Consumer Product Safety Act, and the Toxic Substances Control Act . . . has greatly increased the need for toxicologists.

The report further states that the implementation of the Toxic Substances Control Act will require 1,000 toxicologists, but that it will not be necessary to invest heavily in massive programs to train graduate students in toxicology:

> Rather, the greatest need is to establish top-flight competence in one discipline and then provide funds to permit

> some cross-training in a related discipline. Many scientists (microbiologists, analytic chemists) and physicians find themselves in less than optimal situations, and are prime candidates for cross training or retraining, as the situation demands. We believe that this kind of situation provides assurance against the possibility of overtraining that has occurred in some areas in the past . . . On balance, we believe that training should be provided for explicitly and carefully monitored to ensure that money is used primarily for retraining of available scientifically trained people, not for a massive or diversionary effort to train new graduate students. "Research and Training in Toxicology for Fiscal Year 1980 and Beyond," p. 39, 40.

We are also concerned with other workforce dynamics such as the public sector's ability to attract and retain qualified individuals into the environmental health sciences. A report by the Conservation Foundation entitled "Training Scientists for Future Toxic Substances Problems" illustrates a potential obstacle to attracting adequate numbers of skilled toxicologists into Federal regulatory agencies: The report states:

> The absence of a federal civil service job category entitled "toxicologist" is a severe impediment to effective recruitment of outstanding toxicologists into the regulatory agencies, since the entire existing federal apparatus for advertising and hiring, as well as for career advancement, is based on the existence of a carefully defined civil service professional ladder. Lacking a civil service category of "toxicologist," if a federal agency wishes to hire a toxicologist, it must fill a job category called "biologist" or "pharmacologist/toxicologist"; the specific qualifications most central to toxicology cannot be taken into account and rewarded adequately. For example, if a GS–13 biochemist acquires additional skills in toxicology, there may not be a job category into which he can be promoted in recognition of his additional skills. Yet it is exactly this kind of cross-disciplinary retraining that is so badly needed to meet the demand for toxicologists in a reasonable period of time.
>
> We strongly recommend that the civil service establish a career category and promotional ladder for "toxicologist." Toxicology is a profession; the establishment of a career ladder will aid the federal government in the recruitment and retention of qualified professionals. The Society of Toxicology, we believe, should address this issue, as should the officials in the federal government whose departments and agencies must recruit and retain highly qualified toxicologists.

The Secretary should give priority consideration to the status of the toxicology workforce and take (or recommend to Congress) appropriate steps to rectify present or future shortages of adequately trained toxicologists, if any. In this regard the Secretary should determine whether our educational institutions and governmental entities (such as NIEHS Research Centers and NIOSH Environmental Educational

Resource Centers) provide opportunities for specialized retraining or cross-training, and if they do not determine how to provide such opportunities. Additionally, the Secretary should study other mechanisms to stimulate and expedite movement into these disciplines and determine how to maintain adequate numbers of personnel in such disciplines.

Additionally, we are concerned about the status of personnel assessment and projection activities performed at the Environmental Protection Agency (EPA). In 1977, the National Research Council of the National Academy of Sciences prepared a report for the EPA entitled "Manpower for Environmental Pollution Control" which made several important findings and recommendations. First, recently EPA has been more interested in implementing its programmatic authorities than in manpower development, which has diminished since the Agency's inception. Second, EPA has not coordinated its programs with the environmental manpower research and training programs carried on by the Department of Health, Education, and Welfare, the Department of Defense and other Federal agencies. Further, the report recommends that EPA play an enhanced role in assisting States and local governments on manpower planning activities.

The Report also criticizes EPA's diminished role in providing critical training for environmental personnel. It states that within EPA the level of support for manpower and training activities and the numbers of personnel trained have declined; funds and personnel allocations available in EPA for manpower purposes have decreased drastically and a number of manpower planning and training activities are being curtailed or phased out completely. EPA funding for manpower-related training programs has decreased from approximately $12 million in 1973 to less than $3 million in 1977 and to a negligible amount for 1980. However, the report attempts a fair appraisal of the cause of this phenomenon. It states:

> In an assessment of EPA performance, it should be noted that Congress, like OMB, is heavily involved. It is clear, following review of pertinent statutes, that the availability and development of environmental personnel do not figure significantly in the legislative history of these statutes. Further, the few provisions expressly dealing with personnel training and development are broadly and vaguely stated, contain no enforcement by those seeking to promote EPA conduct of its personnel development functions. Insufficient Congressional consideration of the personnel development issue has continued, despite various studies of EPA pollution control efforts in which the findings repeatedly indicate the lack of adequately trained personnel has contributed to the Agency's inability to meet various statutory requirements. . . . EPA has, by any measure, paid little attention to the personnel requirements associated with the large regulatory programs it tries to implement. Indeed, the Agency has made itself virtually unaccountable of the environmental personnel issue. No short- or long-range plans or studies of any detail and coherence have been made publicly available. (Manpower for Pollution Control 131–133.)

The report is also critical of the Agency's decision to reduce its in-house, short-course training efforts in favor of contracting out such programs. The Report states that contracting-out of direct training services deprives EPA employees of direct exposure to and interaction with, State and local environmental personnel who attend such courses.

We are concerned that EPA's 1981 plan for environmental workforce development represents a reduction in funds and personnel from funding levels for previous years. We expect the Administrator of EPA to elevate Agency concern over the status of the environmental workforce and to work with the Secretary in the performance of the tasks mandated by this section.

We expect the Secretary to determine the efficacy of existing education and training programs at the Federal level and determine whether current Federal efforts are adequate to stimulate entry into and promote sophistication and expertise in the environmental and occupational health fields. The Environmental Protection Agency played a substantial role in the training of environmental personnel until 1977. We believe that the Secretary should determine the utility of giving the Agency responsibility for training certain types of environmental personnel.

Additionally, the Secretary should determine whether training programs in environmental and occupational health in schools of public health and other institutions are funded at adequate levels and whether special project grants for curriculum enrichment for schools of public health and schools of medicine and other institutions are stimulating, interesting, and innovative approaches to the public health aspects of environmental pollution. The situation at Love Canal is convincing proof that we need to train our physicians to detect, understand and treat human illness brought about or exacerbated by environmental contamination. Also, we feel that an innovative, challenging curriculum is one factor that will stimulate entrance into a career field.

We believe the Secretary is in a unique position to be able to tap the rich administrative and educational resources that are concerned with environmental and occupational health issues and determine how to marshal these resources in a cooperative venture to assess the responsiveness of our educational entities in preparing students to deal with complex environmental problems. The Secretary should bring together representatives of entities such as the Environmental Protection Agency, the Secretary of Education, the National Institute for Environmental Health Sciences, the Occupational Safety and Health Administration and educational institutions to study and discuss environmental and occupational health issues and the role of the educational institutions in training individuals to deal with such issues.

In requiring the Secretary to study the need for a register of personnel engaged in all aspects of environmental and occupational health, we were motivated by the perceptions that the disciplines subsumed within the category of environmental and occupational health personnel are broad and often not easily susceptible of specific classification. A study prepared for this Committee, entitled "A Report on Public and Community Health Personnel" by the Bureau of Health Manpower, Health Resources Administration (U.S. Department of

Health, Education and Welfare, December 7, 1979) relates the difficulties inherent in attempting to quantify and assess the community and public health workforce (which includes environmental health personnel). The report states:

> Because of the interdisciplinary nature of public health and the wide variety of individuals working within the field, a systematic classification of personnel is difficult to produce. . . . In public health work, combinations of very different types of skill and knowledge are often required. No single pattern of education, training, and experience is found (or possibly even desirable). This should be kept in mind, for it will complicate attempts at precise identification and definition of certain types of personnel for data collection purposes. . . . Little is known about requirements or shortages of manpower, and less about geographic and organizational distribution. To some extent this is due to the absence of fixed qualifications for jobs falling within the work force as defined above. If a well-qualified person cannot be found, someone will probably be hired to do the job as best he can; hence no vacancy exists and no shortage. As a result, both employers and educators stress the importance of improving skills in the current work force. (p. 1–6)

The report cites "Manpower for Environmental Pollution Control" (referred to above) in stating that in 1977 there were 135,000 professionals employed in environmental protection or pollution control, and that 60 percent of these professionals were civil, mechanical, environmental chemical, etc., engineers and that others were chemists, agricultural and biological scientists, earth and other physical scientists and social scientists.

A smaller segment of the workforce, believed to number 25,000 is concerned with the human health implications of environmental contaminants. The report includes in this category sanitarians, industrial hygienists, engineers, toxicologists, and scientists. In 1979 there were 18,000 to 20,000 environmental health practitioners, about 5,000 to 5,200 industrial hygienists and a small, but indeterminate number of environmental health scientists; about 80 percent of these individuals are employed in Federal, State and local government health departments, environmental protection agencies and other agencies. It is important to note that the report found that no specific trend data are available presently. However, the report cites a National Environmental Health Association projection that by 1990 an additional 10,000 sanitarians (environmental health technicians/technologists) will be needed, and more importantly, that there exist today chronic shortages of certain specialized personnel such as epidemiologists and biostatisticians.

We feel that the Report on Public and Community Health presents a valuable study and assessment of the status of a small, but important, segment of the environmental health workforce. However, it is necessary to assess workforce dynamics and project personnel needs of the 1980's and 1990's. Certainly one valuable first step could be to inventory the existing environmental and occupational workforce. The Sec-

retary should study the utility of using existing resources such as the myriad studies cited in the "Report on Public and Community Health Personnel," the Association of Schools of Public Health Data Center, other agency and departmental data systems and data sources, and projection models from the National Science Foundation, Bureau of the Census and Bureau of Labor Statistics. We believe that knowledge of the factors and variables at work in shaping the dimensions and characteristics of the current workforce will serve as a foundation for effective manpower projection capabilities.

Andrew Maguire.
Richardson Preyer.

MINORITY VIEWS ON H.R. 7203, THE HEALTH PROFESSIONS EDUCATIONAL ASSISTANCE AND NURSE TRAINING AMENDMENTS

While few will argue with the purpose of this health manpower and nurse training legislation, which is to improve access to, and the quality of, medical services in America, the way in which this bill seeks to achieve that objective is worthy of a few additional comments.

The first of these involves one of the basic premises upon which H.R. 7203 is based—the existence of a geographic and a specialty maldistribution of health professionals. Significantly, in light of Administration opposition to capitation grants to schools training health professionals, a new HEW report on the supply of physicians and other health care providers was released just ten days before the subcommittee markup of H.R. 7203. That report indicated the supply of doctors will be at least adequate, if not slightly in excess of need by 1990, a development which, in the words of the report, "could bring about an unprecedented ability to balance supply and demand for health services." This, in turn, suggest two things: (1) that the law of supply and demand may be even more effective than the government in encouraging physicians to practice the kind of medicine that is most needed in areas where health care is least available and (2) that, if previous estimates of aggregate shortages have been exaggerated, then the maldistribution problem may have been overstated as well.

The second comment derives from the first. If the health services maldistribution problem has been overstated, or is well on the road to resolution as is indicated not only by the aforementioned report but also by past statements by the President with regard to the supply of nurses, then is it not time to declare victory and set a deadline for phasing health manpower legislation out? Failure to do so, given the long lead time necessary to terminate health training programs without being unfair to the participants, could result in the unnecessary consumption of tax dollars for far longer than is necessary.

Third, there is the interaction between students assistance programs, the National Health Service Corps, institutional assistance requirements, inflation, and the would-be health professional. Not only are the medical schools required to have a certain percentage of their students enrolled in primary care programs to be eligible for capitation (or institutional assistance as it is termed in this bill), but, thanks to inflation and the rapidly rising cost of tuition, those students and others are being forced to consider government service in health manpower shortage areas to cover tuition or to pay off existing loans. While no one can argue with the idea of making better medical care available to those who need it, the way in which this combination of factors comes into play gives the federal government more and more control over what kind of medicine health professionals practice and where

they practice it. Should this trend continue, and the emphasis being put, both financial and otherwise, on the National Health Service Corps (NHSC) suggests that it will, we could find ourselves faced one day with a system not all that different from the British National Health Service where many of the physicians work for the government instead of for the individual patient. Given the well documented failures of that system, of which de-personalized medical care is but one, Members, students and patients alike should ask themselves again if this is really the route they want to go.

Admittedly, the inclusion of the "private placement option" and the improvements of existing laws, "private practice" option contained in the NHSC section of the bill mitigate this problem somewhat but not sufficiently so that it can be forgotten. Instead, there is a need to monitor future developments and for Congress to look for more ways to stimulate private rather than federal responses to the health care needs of this nation.

Finally, credit should be given where credit is due. The adoption of the Luken Amendment at the subcommittee level, which substantially reduced authorizes from the levels originally proposed, was a most encouraging development. Instead of a 26.9 percent increase in funding (over fiscal year 1980 appropriations); H.R. 7203 now authorizes "only" a 19.2 percent increase for fiscal year 1981. That figure is still too high, what with inflation having averaged 18.2 percent during the first quarter of 1980, but it is a considerable improvement. Hopefully, therefore, the Luken Amendment is an harbinger of things to come, not only in the area of well-intentioned health legislation but in other areas as well.

○